IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS

J.B.H., by his next friend Debra Medlock, and A.M., by his next friend Rachael Puig, on behalf of themselves and all others similarly situated,	)	
Plaintiffs,	)	
v.	)	Case No. 24-cv-04096-JES-JEH
KNOX COUNTY, CHIEF JUDGE RAYMOND A. CAVANAUGH of the Ninth Judicial Circuit Court, BRIDGET E. PLETZ, Director of Court Services of the Ninth Judicial Circuit Court, and WENDI L. STECK, Superintendent of the Mary Davis Home,	)	Hon. Judge James E. Shadid
Defendants.	)	

AMENDED CLASS ACTION COMPLAINT

Plaintiffs J.B.H. and A.M., on behalf of themselves and all others similarly situated, by and through their undersigned counsel and next friends, hereby file this Class Action Complaint against Defendants Knox County ("County"), Chief Judge Raymond Cavanaugh, Bridget E. Pletz, and Wendi Steck, (collectively, the "Defendants"), and allege as follows:

INTRODUCTION

1. Mary Davis Detention Home ("MDH" or "the Center") detains children as young as 11 years old. The children who make their way to the Center are a uniquely vulnerable population; many have suffered abuse and trauma in their lives and face significant mental health issues that predate their incarceration. Once detained, these children are under Defendants' exclusive, full-time care at a crucial point in their physical, psychological, educational, and social development. MDH has the responsibility of raising these children for the time they are within the walls of the facility. But instead of caring for them, Defendants subject them to prolonged solitary

confinement that is well known to cause lasting harm, especially to the young.

2. Children at MDH spend the majority of their time in solitary confinement. Day in and day out, these children spend at least nineteen to twenty hours per day confined in their cells. But Defendants often enhance this already excessive confinement, imposing twenty-three-hour-a-day solitary confinement as a form of punishment, even for relatively trivial and nonviolent infractions. They also place youth on "Behavioral Plans" that involve punitive confinement of twenty-one to twenty-two hours per day. These punishments are often imposed for multiple consecutive days at the whim of jail staff, usually without notice or any explanation as to when the punishment will end.

3. Defendants maintain this culture of solitary confinement in the face of the extensive and settled body of research showing that the practice inflicts immeasurable harm on children and is wholly inappropriate in a juvenile detention setting. The inhumanity of the practice is reflected not only in a widespread clinical consensus, but in the judgments of institutions both global and local. The United Nations, for example, strictly prohibits youth solitary confinement. The United States Department of Justice has condemned the practice and banned it from federal prisons. The Illinois Department of Juvenile Justice has long since banned the practice of extended punitive solitary confinement in its facilities. In June 2023, the Illinois legislature enacted the "End Youth Solitary Confinement Act," which severely limits the practice in juvenile detention centers, recognizing the significant harm it inflicts on children. The Mary Davis Home knowingly persists with this practice nonetheless.

4. The harm of solitary confinement is amplified by the conditions in which MDH detains the children in its care. The fluorescent lights in their cells are never turned off, making sleep difficult to impossible. Children have long been forced to eat meals alone in their cells, just

a few steps away from the toilet where they have to defecate. They are denied needed exercise. The meals they consume are nutritionally inadequate, with youth on punitive confinement forced to eat the worst food of all. While confined, children are cruelly denied basic human interaction, let alone the kind of activities and programming they should be receiving. They are left to pace their tiny, brightly lit concrete cells alone for days, weeks, or even months.

5. Children at MDH have limited access to mental health care, which is a significant concern given the complex needs of the youth in detention. There are no mental health professionals on staff at the facility. There is one social worker who visits the children 2-3 times per week but is not equipped to provide the kind of urgent mental health intervention these children need.

6. The facility imposes punitive solitary confinement on children known to suffer mental illness. And even though children in isolation have heightened mental health care needs, the facility perversely diminishes their level of care: they are only given access to the social worker for minutes at a time, all within earshot of the other youth present in their living area. This is the level of care provided even to children in acute mental health crisis, such as those placed on "suicide watch."

7. MDH does not provide children detained in the facility anything resembling an education during their time there. Their "school" consists of self-guided worksheets that they complete on their own, often in their living areas steps from their cells. There are no special education services for youth who need them. Many youth go days or weeks without any schoolwork at all.

8. Children at MDH have long been subjected to facility-wide strip searches as well. Traumatic, invasive, fully naked strip searches are a routine part of life at MDH, frequently

conducted without any individualized suspicion and without first attempting less intrusive searches. Youth are often subjected to facility-wide strip searches that necessarily invade the privacy and bodily sovereignty of, and inflict trauma on, a far broader group of youth than necessary.

9. Defendants have maintained these conditions in the face of multiple public warnings about the facility's urgent deficiency. The Illinois Department of Juvenile Justice, which is responsible for auditing juvenile detention centers in the state, has warned MDH over and over that its extensive isolation of youth is inappropriate. The State has warned that confinement is not to be used for punishment, and youth should be confined only for very short time periods in extreme circumstances. Yet the facility continues to confine youth to their rooms for days and even weeks at a time, with full knowledge that it creates substantial risks of serious harm for the children in their care.

10. IDJJ has further warned MDH about its inadequate educational services, use of force, and inadequate mental health care; all these problems have persisted. At least two other State agencies have also publicly rebuked MDH's detention practices and conditions.

11. Despite these many warnings from IDJJ, the County knowingly allows MDH to continue to operate with significant use of solitary confinement and fails to provide adequate mental health staffing to at least mitigate the harms caused by the persistent isolation it knows to be the norm at MDH. The remaining Defendants supervise and oversee the abusive day-to-day environment that festers in a facility that resolutely refuses to allow the children in its custody more than fleeting respite from maddening solitary confinement.

12. The history of MDH teaches that the current unconstitutional conditions will persist unless this Court stops them. The named Plaintiffs, and the putative class of detained children

described below, seek declaratory and injunctive relief requiring Defendants to provide constitutionally adequate conditions of confinement at MDH, including mental health and educational services.

JURISDICTION AND VENUE

13. This Court has subject matter jurisdiction under 28 U.S.C. §§ 1331 and 1343(a)(3) because this action presents federal questions and seeks to redress the deprivation of rights under the Eighth, Fourth, and Fourteenth Amendments to the U.S. Constitution.

14. Venue is proper in this Court under 28 U.S.C. § 1391(b)(2) because the events and omissions giving rise to the claims asserted herein occurred within this judicial district.

15. This Court is authorized to grant declaratory and injunctive relief under 28 U.S.C. §§ 2201 and 2202 and Rules 57 and 65 of the Federal Rules of Civil Procedure.

PARTIES

16. Plaintiff J.B.H. is a 17-year-old boy who is currently detained at MDH. Plaintiff J.B.H. is identified by his initials in accordance with Federal Rule of Civil Procedure 5.2 because he is a minor at the time of this action. J.B.H. has been detained at MDH since around March 29, 2024, when he was last admitted. He appears in this action through his guardian, Debra Medlock. J.B.H. sues on his own behalf and on behalf of the putative class.

17. Plaintiff A.M. is a 15-year-old boy who is currently detained at MDH. Plaintiff A.M. is identified by his initials in accordance with Federal Rule of Civil Procedure 5.2 because he is a minor at the time of this action. A.M. has been detained at MDH since around March 10, 2024. He appears in this action through his mother and guardian, Rachael Puig. A.M. sues on his own behalf and on behalf of the putative class.

18. Defendant Wendi Steck is the Superintendent of MDH. As Superintendent of

MDH, Defendant Steck plays a central and active role in the alleged constitutional deprivations outlined in this Complaint. Defendant Steck is involved in either establishing, executing, or having detailed knowledge and direct control over the Center's daily operations and policies, including in areas such as the use of confinement, strip searches, educational services, and medical and mental health care. Defendant Steck is also responsible for ensuring that the facility complies with the Illinois Department of Juvenile Justice's juvenile detention center standards. Defendant Steck is sued in her official capacity.

19. Defendant Chief Judge Raymond Cavanaugh of the Ninth Judicial Circuit Court is the official statutorily authorized to have administrative and supervisory authority over MDH. In this role, Defendant Chief Judge Cavanaugh is responsible for overseeing, directing, and ensuring the safe, secure, and efficient operation of the facility. On information and belief, Defendant Chief Judge Cavanaugh, along with Defendant Pletz and Defendant Knox County, is responsible for hiring an adequate number of staff at the facility, including the Superintendent, to operate the Center. Defendant Chief Judge Cavanaugh is also responsible for ensuring that the facility complies with the Illinois Department of Juvenile Justice's juvenile detention center standards. Defendant Chief Judge Raymond Cavanaugh is sued in his official capacity.

20. Defendant Bridget Pletz is the Director of Court Services for the Ninth Judicial Circuit Court, and oversees the administration and supervision of MDH along with Defendant Chief Judge Raymond Cavanaugh. On information and belief, Defendant Pletz is responsible for assisting with hiring jail staff, including the Superintendent, as well as evaluating the Superintendent's performance. Defendant Pletz is also responsible for ensuring that the facility complies with the Illinois Department of Juvenile Justice's juvenile detention center standards. Defendant Pletz is sued in her official capacity.

21. Defendant Knox County (the "County") is the unit of local government that chose, through its governing body the Knox County Board (the "Board"), to build MDH and that is responsible for continuing to fund and maintain it. On information and belief, the County, acting through the Board, is responsible for the facility's budget and finances, including establishing an annual budget for the Center's operation and paying its debt service. The County is responsible for paying staff salary and benefits, as well as hiring individuals or independent contractors to provide necessary support services at the facility, including the Center's health care delivery system. The County is responsible for providing all essential equipment and supplies for the Center's operation, as well as the expense of training staff. The County is also responsible for ensuring that the facility complies with the Illinois Department of Juvenile Justice's juvenile detention center standards. The County, acting through its Board, has final policymaking authority for MDH.

22. Defendants each establish and have responsibility for establishing policy, custom, and practice that shape the lives of the children detained at MDH.

BACKGROUND

23. MDH is a 39-bed facility in Galesburg, Illinois. Each year, it houses dozens of children between the ages of 11 and 17 from multiple counties across Illinois.

24. Children detained at MDH have, for the most part, not been adjudicated delinquent or convicted of the crime for which they were arrested. Youth in MDH are locked in the facility while they wait for trial, sentencing, and/or transfer to another facility.

25. The children at MDH are housed in four separate housing pods labeled Upper East, Lower East, Upper West, and Lower West. These pods are single-occupancy cells. The facility has also used a fifth housing pod—referred to as the "Harvest Wing"—as a dedicated punitive confinement area the children refer to as "Seg," though MDH has paused use of the Harvest Wing

after negative attention from the IDJJ's 2022 and 2023 audits. The facility did not end the practice of punitive confinement; instead, the facility merely moved segregated solitary confinement from a dedicated wing back to youth living spaces, where youth endure extended solitary confinement in their own cells.

26. The cells in each pod are arranged around a common hallway area which includes a small couch and in some cases a television attached to one wall. Between the pods is a central control booth with an intercom that allows two-way communication between the children in the cells and the jail staff stationed in the control booth. However, MDH staff do not allow children to use the intercom, forcing children to resort to shouting and yelling to get staff attention.

27. The population of children detained at MDH varies over time, though there are typically 15 to 25 children at MDH on any given day.

28. Children are often held at MDH for weeks at a time. It is not uncommon for youth to be locked in MDH for multiple months, or even a year or more.

I. MDH Detains Children in Severe and Unconstitutional Solitary Confinement and Subjects them to Traumatic and Unconstitutional Strip Searches

29. MDH routinely subjects children to extended solitary confinement in conditions that are shockingly inadequate and affirmatively abusive. Defendants inflict this harm on children known to have serious mental health conditions, and children in such acute mental health crisis that the facility itself has placed them on "suicide watch."

30. MDH also subjects the children in its care to invasive, humiliating, and traumatic facility-wide strip searches without reasonable, individualized suspicion.

31. Four youth currently or recently detained at the facility for extended periods of time—J.B.H., A.M., N.J., and M.P.—experienced these conditions first-hand.

A. J.B.H.'s Experience at MDH

32. Plaintiff J.B.H. is a 17-year-old boy from Rock Island, Illinois who has been detained multiple times at MDH over the past three years. He has spent over six months at the facility during that time. J.B.H. currently lives at the facility, where he has been detained since approximately March 2024. J.B.H. was also detained at MDH for about a month in December 2021, and for about two months in early 2022. The third time was for around a month in April 2022, and the fourth was in late 2022. *See* Declaration of J.B.H. ("J.B.H. Decl."), attached hereto as Exhibit 1, at ¶ 2.

33. Although he has lived in all of the different living wings throughout the facility, J.B.H. is currently housed in Lower East wing, where he is detained with approximately 3 other children at the time of filing. According to J.B.H., all the cells in the living wings are the same: concrete boxes about the size of a parking space with barely enough room to move around. They have a concrete slab with a thin mattress on top of it, and a combined sink and toilet a few feet away. *Id.* at ¶ 4.

34. J.B.H. spends almost all his time in his cell at MDH. J.B.H. spends a minimum of about 23 hours per day in his cell and has for several weeks prior to filing. *Id.* at ¶ 6. As J.B.H. puts it, SGS means children are "in solitary confinement basically all day every day." *Id.* at ¶ 6. J.B.H. was placed on "Special Group Status," or "SGS," as punishment for refusing to return to his cell in protest after staff refused to give him his medication. *Id.* at ¶ 7.

35. SGS is a punishment that involves staff placing youth in their cell for extended solitary confinement with no escape save for a brief shower and two short "recreation" periods of about 15-30 minutes each. *Id.* at ¶ 6. Children on SGS eat all their meals in their cells. *See id.* at ¶ 6. MDH staff dictate the location and activities for these limited recreation times. *Id.* at ¶ 14. For

instance, on May 24, 2024, in the early afternoon, J.B.H. mentioned that it was his first time out of his cell all day and he returned to his cell after the legal visit, as staff considered his legal visits and calls to be part of his "rec" time. *Id.* at ¶ 14.

36. Staff have not told J.B.H. when he can expect his SGS status to end, which is their typical practice. *Id.* at ¶ 7. According to J.B.H. believes there were about four other youth on SGS restriction at the time counsel spoke with J.B.H. shortly before filing. *Id.* at ¶ 9. But J.B.H. has seen as many as seven other kids on SGS at a time. *Id.* In J.B.H.'s experience, SGS status can last anywhere from 1 day to 3 months. *Id.* at ¶ 8.

37. In J.B.H.'s experience, kids get placed on SGS restriction for a variety of reasons. He has seen kids placed on SGS restriction for cussing at staff. *Id.* at ¶ 7. J.B.H. says the staff can place kids on SGS for whatever they want. *Id.*

38. J.B.H. is incredibly bored when locked alone in his cell. *Id.* at ¶ 12. There is nothing to do but walk a few feet back and forth and stare at the wall, particularly because he is not allowed any books while on SGS restriction. *Id.* He is forced to eat by himself in his cell, with a plate of food handed to him three times a day and picked up by staff later. *Id.* Staff tell youth they are not allowed to talk between cells and can discipline them if they are caught communicating. *Id.*. But this kind of contact is important to J.B.H.—talking through cell doors is almost all the human contact he is allowed, particularly when he is on SGS restriction. *Id.* The only other daily human contact J.B.H. has is with staff during food drop-offs and occasional checks. *Id.*

39. J.B.H. is a naturally high-energy person and sitting in his cell for hours on end "messes with [his] head." *Id.* at ¶ 12. He feels that his extended isolation is really hurting his mental health; he sometimes cries when he is alone in his cell and feels hopeless and depressed. *Id.* at ¶¶ 12, 39. J.B.H. says that the facility is making him go crazy. *Id.*

40. SGS restriction is not the only enhanced solitary confinement MDH staff use to punish youth. Youth can also be placed on "Behavioral Plans," which also involves extended confinement in their cells. *See id.* at ¶ 10. Although youth on behavioral plans can come out of their cells during regular recreation time, they are restricted from engaging in typical recreational activities. Instead, they must complete their "plan," which includes completing paperwork and participating in meetings with staff. *See id.* As J.B.H. describes it, a "Behavioral Plan" is a lot like SGS except that you spend 21-22 hours in your cell instead of 23 and have meetings and paperwork to complete. J.B.H. has been on a Behavioral Plan at least four times during his recent stay at the Center. *Id.* at ¶ 11.

41. Even before he was placed on SGS restriction J.B.H. spent the vast majority of each day at MDH alone in his cell. *Id.* at ¶ 13. He came out of his cell for recreation periods, meals, showers and school for a total of about three hours per day. *Id.* The other twenty to twenty-one hours were spent in his cell in the same way as during SGS restriction. *Id.*

42. J.B.H.'s cell, where he now spends the majority of his young life, is not a place where he can get any rest. It has fluorescent lights on the ceiling that never turn off—it is brightly lit all day and all night, which makes it very difficult to sleep. *Id.* J.B.H. does not remember the last time he got anything close to a full night's sleep, and he is constantly exhausted. *Id.* at ¶ 18.

43. J.B.H. is currently so mentally anguished that staff has placed him on "suicide watch." *Id.* J.B.H. told staff at the Center that he had suicidal thoughts. *Id.* J.B.H. has been on suicide watch for the last three or four weeks. *Id.* at ¶ 20. When children are on suicide watch staff remove their sheets from their beds for safety reasons, and replace normal food utensils with rubber ones for fear that youth might use them to cut themselves. *Id.* at ¶ 21. The staff will also sometimes strip children on suicide watch of their clothing and replace it with what is known as the "turtle

suit"—a green fabric smock secured with Velcro designed to prevent self-harm. *Id.*

44. For a child in J.B.H.'s situation—who is both isolated on SGS restriction and in such acute mental crisis that he has been placed on suicide watch—access to mental healthcare is crucial. Yet J.B.H. does not have access to meaningful mental healthcare at MDH at all. *Id.* at ¶ 19. The extent of his mental healthcare is brief, routine check-ins from an outside social worker who visits his wing approximately 2 or 3 times a week. *Id.* at ¶ 22. As of his conversation with counsel shortly before filing, J.B.H. only received daily visits from the social worker for 15 minutes or less but these visits happen when J.B.H. is surrounded by other children within earshot, which makes private and confidential communication impossible. *Id.*

45. There is no additional mental health treatment available to J.B.H. beyond the periodic short visits from the outside social worker. *See id.* J.B.H has requested to speak with other mental health professionals like Bridgeway, but staff at MDH tell him that Bridgeway declines and refuses to speak with children at MDH. Staff do not provide any further explanation for this refusal. *Id.* at ¶ 20. The extended solitary confinement has made J.B.H.'s mental health crisis much worse, and he does not understand how a facility could think it is a good idea to punish kids on suicide watch with more solitary confinement. *Id.* at ¶ 17.

46. J.B.H continues to feel suicidal, especially due to the extensive time spent in confinement. *Id.* at ¶ 20. J.B.H. does not feel like MDH takes children on suicide watch seriously. *Id.*

47. J.B.H. has not attended full-time school at MDH. *Id.* at ¶ 24. Since being placed on SGS he has stopped attending school at all, not even for passive reading or completing written packets. *Id.*

48. Even before his SGS restriction, J.B.H. never set foot in the facility's single

classroom during his most recent stay, or his previous stay. *Id.* ¶ 24. The only "schooling" J.B.H. received during his most recent stay was the opportunity to complete pre-assembled document packets while sitting in the facility's shared dayroom space. *Id.* This was done for 30-45 minutes each school day with no live instruction or even supervision from the facility's one teacher. *Id.* J.B.H. described the packets as "third-grade work" that did not challenge him at all. *Id.* Worse yet, during his stays at the facility J.B.H. has received the same educational packets over and over. *Id.* He has not seen them graded or marked up. *See id.* J.B.H. says there is no way to describe what he has done in MDH as "school" at all. *See id.* J.B.H. used to go to school every day in the community and enjoyed classes like science and business. *Id.* at ¶ 27. But being at MDH has set back his progress. *Id.* He is not sure if he is on track to obtain his GED. *Id.* at ¶¶ 25-27.

49. J.B.H. does not get any personal visits when he is on SGS status. He typically gets 2 personal telephone calls per week, each limited to 15 minutes. J.B.H. is limited to attempting phone calls during his two thirty-minute "recreation" periods outside his cell. *Id.* at ¶ 17. When J.B.H. makes a call during his rec time, it eats into the time he has for anything else outside his cell. If the person J.B.H. is calling is not available during the short rec window, J.B.H. cannot talk to them. This has limited J.B.H.'s ability to speak to his grandmother and guardian, and the cutoff of contact has been difficult for both of them. *Id.*

50. J.B.H. does not have access to adequate medical care at MDH, which only has a part-time nurse, but she has not been helpful. *Id.* at ¶ 28. MDH staff routinely withhold medication he was prescribed at an IDJJ facility without explanation. *Id.* He has also been denied pain relief medication when he had a headache so severe he felt like his head was splitting open. *Id.* at ¶ 29. Because it was the weekend and the nurse was unavailable, the staff informed him that he would have to wait until she returned to the facility the following Monday. *Id.*

51. The food portions at MDH are inadequate, often leaving J.B.H. hungry after each meal he eats in his cell. *Id.* at ¶ 30. Being on SGS restriction means receiving different and often less desirable food options than children not on SGS. *Id.* at ¶ 31. For instance, while other children were given fried chicken, J.B.H. had to eat a plain chicken patty. *Id.* On another occasion, while other children were given McDonald's, J.B.H. was not allowed to have it due to his SGS status. *Id.* J.B.H. also cannot purchase snacks from the commissary when he is hungry because of his SGS status. *Id.*

52. J.B.H. does not believe there are enough staff at MDH to operate the facility. *Id.* at ¶ 32. There are typically four or five staff on duty at a given time, with one remaining in the central "control booth." *Id.* Staff regularly complain about not having enough staff to watch the youth and say that lack of staffing is the reason kids spend so much time in their cells. *Id.*

53. J.B.H. has received rough physical treatment from staff. A few weeks ago, he was upset about the staff's regular failure to administer his medications in a timely way, and so decided to refuse to return to his cell until staff gave him his medication. *Id.* at ¶¶ 7, 34. After the nurse refused to give J.B.H. his medication a second time, he got upset. *Id.* at ¶ 34. While in his cell, a staff member handcuffed him while he was lying face down on the floor. *Id.* The staff member then applied pressure to J.B.H.'s back and neck area with his knee to further restrain him. *Id.* J.B.H. remained in this restraint until MDH called local sheriffs' deputies. *Id.* J.B.H. says that it is typical for police to be called in when youth are shackled. *See id.* at ¶ 36. J.B.H. has seen staff call local police to come to the facility on multiple occasions when there are behavioral incidents and not enough staff to deal with them. *Id.*

54. Just the week prior to filing, a staff member restrained J.B.H. with a chokehold and punched his arm while he was holding a door. *Id.* at ¶ 35. The staff member also pulled one of

J.B.H.'s dreadlocks completely out of his head and left it in his cell. *Id.* Afterward, J.B.H. was left shackled in his cell, and staff confiscated his mattress and belongings. *Id.* Staff members tore up J.B.H.'s important paperwork—including a letter and song lyrics he was working on, and important phone numbers—right in front of him. *Id.*

55. J.B.H. has been subjected to a facility-wide strip search while at the facility. *Id.* at ¶ 37. During his second stay, staff pulled each youth out of his cell into the hallway and ordered them to strip naked. *Id.* Some youth were stripped in the hallway, while others were stripped in their cells, including J.B.H. *Id.* The staff did not explain to J.B.H. why they were mass strip searching or what they were looking for. *Id.* When staff got to J.B.H.'s cell, there were 3 staff members conducting the search. They ordered J.B.H. to strip completely naked, turn around, bend over, and cough. *Id.* J.B.H. found this strip search humiliating and traumatic, and felt particularly violated. *Id.* at ¶ 38.

56. J.B.H.'s experience at MDH has taken a serious toll on him. *Id.* at ¶ 39. The persistent confinement, feelings of loneliness and isolation are significantly impacting his well-being and mental health. *Id.* He constantly feels like he is going crazy. *Id.* He feels like nobody at the facility understands what he is going through, and when he tries to talk to the staff about it, they do not listen. *Id.* In the facility, he experiences feelings of isolation, depression, anger, and helplessness. These emotions weigh heavily on him. *Id.*

57. J.B.H.'s experiences at MDH have had a profound impact on his transition back into the community after release. *Id.* At home, he finds himself wanting to stay in his room and be quiet because he still feels the lingering effects of confinement and isolation. *Id.* Even in the familiar surroundings of his home, the trauma of his time at MDH persists, making it difficult for him to fully integrate back into everyday life. *Id.*

58. J.B.H. observed that the other youth at MDH spend the vast majority of time in their cells, they are all liable to get punished with additional confinement in the form of SGS restriction or Behavioral Plans, they are all subject to mass strip searches, none of them receive adequate education, and they all face violence at the hands of staff. *See id.* at ¶¶ 5, 9, 12, 22, 24, 33, 36, 37.

59. J.B.H. has spent time at other detention facilities as well, including Illinois Department of Juvenile Justice facilities and Focus House in Rochelle, Illinois. MDH is far worse than any of them, especially because of the time kids have to spend alone in their cells. *Id.* at ¶ 41.

60. J.B.H. has repeatedly complained to staff about the conditions in the facility and never received any response or remediation. *Id.* at ¶ 40. He feels that the voices and needs of the children at the facility are routinely overlooked and dismissed. *See id.*

B. A.M.'s Experience at MDH

61. A.M., a 15-year-old boy from Rock Island, Illinois, has been detained at MDH twice, totaling about four months. His most recent detention began around March 10, 2024. *See* Declaration of A.M. ("A.M. Decl."), attached hereto as Exhibit 2, at ¶¶ 1-2.

62. For the majority of his current detention at MDH, A.M. has been placed on SGS, where he spends 23 hours a day in his room.

63. While on SGS, A.M. is trapped in his small cell all day, every day. He eats all his meals there. *Id.* at ¶ 5. The lights in the cell never turn off, day or night, which makes it extremely difficult for A.M. to sleep. *Id.* at ¶ 15.

64. A.M. is allowed two 30-minute recreation periods outside his cell, although these are sometimes shortened by staff. *Id.* at ¶ 4. When A.M. gets this recreation time, staff mostly allows him to spend these precious few minutes sitting in his wing watching TV. *Id.* at ¶ 9. Despite

being a physically active teenager in the community, playing basketball and football, he rarely gets access to the gym and basketball court. *Id.* at ¶¶ 9-10. He has limited opportunities for exercise, but tries to make up for it by doing push-ups in his cell. *Id.* at ¶ 10. This lack of physical activity frustrates him. *Id.*

65. There are currently three other children on SGS with A.M., but he has seen as many as seven children on SGS at one time. *Id.* at ¶ 7.

66. Because staff does not tell A.M. when he will be taken off SGS, it feels like he is being punished indefinitely. *Id.* at ¶ 8. He works to suppress and regulate the anger that builds up from his constant confinement, knowing that showing it may lengthen the time he is forced to sit alone in his cell. *Id.* at ¶ 21. He feels trapped. *Id.*

67. A.M. is supposed to be a freshman in high school but has not attended school regularly, if at all, during his most recent time at MDH. *Id.* at ¶ 12. He does not attend school at all while on SGS status. *Id.* He only received packets twice and found them easy and repetitive. *Id.* They were never graded nor was he given feedback. *Id.* He has not interacted with the MDH teacher and has never been in the classroom for school. *Id.*

68. While on SGS, A.M. rarely interacts with mental health professionals or anyone else for that matter. *Id.* at ¶ 13. When a counselor visits the facility, which is only about twice a week, their interaction with SGS kids like A.M. is brief. *Id.* The counselor only meets with A.M. in his wing, stands outside A.M.'s cell door, and asks just a few questions. *Id.* The counseling session lasts only about five minutes. *Id.* A.M. feels unable to be truly honest about his feelings during these brief interactions, especially since other kids can overhear the conversation. *Id.*

69. A.M. takes medication for diagnosed mental health conditions, but staff at MDH sometimes withhold his medication without explanation. *Id.* at ¶ 14. This makes A.M. feel like he

is being punished. *Id.* Missing even a day of medication worsens A.M.'s symptoms, leading to night sweats and traumatic flashbacks. *Id.* at ¶ 15. The constant bright lights in the facility, even during sleeping hours, makes it difficult for A.M. to sleep even without medication interruptions, but staff's withholding of medications makes sleep even more difficult to come by. *Id.*

70. A.M. has observed other children placed on suicide watch. *Id.* at ¶ 16. Staff mark a child as on suicide watch by sticking a bright tag outside their cell door. *Id.* Those on suicide watch typically remain in their cells for extended periods and do not receive additional services or medical attention. *Id.* A.M. characterizes being on suicide watch as just solitary by a different name. *Id.*

71. A.M. describes the staff at MDH as "rough," "aggressive," and physically violent for "no good reason." *Id.* at ¶¶ 17, 21. He has witnessed them "throw kids" and "slam them" against walls. *Id.* On two occasions, A.M. himself experienced violence from staff members. *Id.* Just last week, the Assistant Superintendent slammed A.M.'s head against his cement cell wall when A.M. did not hand over his hygiene cup quickly enough. *Id.* Another time, a different staff member slammed A.M.'s head against the gym wall so forcefully that he suffered a mild concussion and had to go to the emergency room. *Id.*

72. During his first stay at MDH, A.M. was subjected to a facility-wide search initiated over a missing pen. *Id.* at ¶ 18. Initially, all children were subjected to pat-down searches and scanned with a body wand downstairs. *Id.* However, A.M. was then taken to an empty cell where he underwent a full search in front of two male staff members. *Id.* He felt violated having to be fully naked and uncomfortable with the level of exposure during the search. *Id.*

73. A.M. often feels hungry even after meals, as he believes he is not given enough food. *Id.* at ¶ 19. Children on SGS also receive less appetizing meals compared to those not on SGS. *Id.*

74. A.M. characterizes MDH as a "bad facility" and the worst he has experienced, primarily because of the extensive time spent in confinement. *Id.* at ¶ 21. In contrast to other facilities where he had more time out of his cell, the constant confinement at MDH takes a toll on A.M. *Id.* He feels "trapped in his own thoughts," and experiences constant agitation and anger. *Id.*

75. As A.M. puts it, the "staff don't see us as kid or even as human beings." *Id.* at ¶ 21.

C. N.J.'s Experience at MDH

76. N.J. is a 17-year-old boy from Rock Island, Illinois who has been detained multiple times at MDH over the past three years, with a total incarceration time of nearly a year and a half. N.J. was detained around September 2022, again in November 2022, and was most recently detained between April 2023 and April 2024. N.J. was housed mostly in the Lower West wing during his most recent incarceration at the facility, often by himself and separated from other youth. He has spent time in all the wings of the facility. *See* Declaration of N.J. ("N.J. Decl."), attached hereto as Exhibit 3, at ¶¶ 1-3, 6. MDH transferred N.J. out of MDH and into another pretrial juvenile detention facility in late April 2024 shortly after he met with counsel.

77. During his last stay at the facility N.J. did not have a pillow, despite requesting one from staff. *Id.* at ¶ 5. He had a sheet and one thin blanket. *Id.* It was cold at night. *Id.* There were bright fluorescent lights on the ceiling of N.J.'s cell that were always turned on, even at night when he was trying to sleep. *Id.* at ¶ 4. The constant bright light made it hard for N.J. to fall asleep, especially combined with a restless and panicked state of mind brought about by prolonged isolation. *Id.* at ¶¶ 3-5.

78. N.J. spent virtually all his time at MDH confined by himself within the four walls of his cell. *Id.* at ¶ 6. He spent about 20 to 23 hours per day in his cell, though usually toward the higher end of that range. *Id.*

79. During the last several weeks of his most recent incarceration at the facility N.J. was on SGS restriction, which was imposed on him as punishment after he "talked back" to staff and refused to return to his room. *Id.* at ¶ 9. Specifically, N.J. argued with a staff member who insisted that he serve a 15-minute disciplinary "time out" alone in his room instead of in the common area of the facility. *Id.* N.J. felt that the staff member disregarded the rules of the facility by forcing him into his room for a time out, and he valued the very limited time he got to spend outside his room during the day, so he refused to return to his room. *Id.* Staff members physically restrained N.J., forced him into his room, and placed him on SGS status, where he remained for several weeks until he was transferred. *Id.*

80. While on SGS restriction N.J. spent around 23 hours a day in his cell. *Id.* at ¶ 6. He ate three meals a day in his cell by himself. *Id.* at ¶ 7. He was only allowed out of his cell for seven-minute showers daily, and (sometimes) about 30 minutes of total "recreation" time, which was spent a few feet away from his cell in a hallway between the cells. *Id.* Even this time was spent by himself. *Id.* He was not allowed outside during his short recreation time, or even allowed to go to the shared living area of the facility to interact with other kids. *Id.* He was not allowed to talk to other youth while in his cell—most of the time there were no other youth to talk to because he was isolated in the wing by himself, as staff moved other youth cells away from his so that N.J. could not talk to them through the cell walls. *Id.* at ¶ 10. His only human interaction was typically with staff who would come by for "checks," but did not talk much, and when they did would sometimes tease and provoke him causing further stress. *Id.* at ¶¶ 10-12.

81. In N.J.'s experience youth are placed on SGS restriction for refusal to follow staff direction, or for trying to advocate for themselves, such as when he protested the in-cell "time out." *Id.* at ¶ 8. Staff never told N.J. how long he could expect to remain on SGS restriction, which made the isolation even harder to endure. *Id.* N.J. explained that staff members sometimes perform an "evaluation" on Wednesdays to review youth SGS status. *Id.* If staff members decided to allow a youth to leave SGS status the youth could return to a "normal" routine; if they decided otherwise, the SGS restriction would be extended. N.J. observed that the same group of staff members who determined initial punishments got to decide how long the punishments continued, so he felt like he had no way out once certain staff supervisors decided they did not like him. *Id.* Even when his punishments were ended N.J. felt that staff would return him to restriction for relatively trivial infractions, like loud talking or joking around. *Id.* During his last period of incarceration staff members eventually told N.J. that he would stay on SGS as long as he remained at the facility (and he did until he was transferred). *Id.*

82. During his most recent stay at MDH, N.J. was placed on SGS restriction four times. *Id.* at ¶ 9. The first time was for approximately one month, soon after he arrived at the facility. *Id.* The second time was for four months between September and December of 2023. *Id.* The third time was for two weeks in December 2023. *Id.* The final time was from March 2024 until he was transferred to another facility. *Id.* All in all, N.J. spent over six months in 23-hour-a-day solitary confinement in a single stay at MDH. *See id.*

83. Being alone all the time and not talking to people had a significant impact on N.J.'s mental health. *Id.* at ¶ 11. He reflected that this kind of isolation "really kills a person on the inside." *Id.* He felt really bored and restless, and it was like time would move so slowly. *Id.* He believes it is inhumane and made him feel like he had been classified as "inhuman." *Id.* N.J.

observed that after a while solitary confinement makes you "feel like you are not there, and like you are not valued by the world." *Id.* He would try to pass the time by reading books, but sometimes the staff would not give him any, or they only gave him books he had already read a dozen times. *Id.* at ¶ 13. It was frustrating and made the isolation even worse. *Id.*

84. The other kind of punitive isolation N.J. experienced was called "Behavioral Hold" or a "Behavioral Plan." *Id.* at ¶ 14. When he first arrived at the facility Behavioral Plans involved more or less permanent isolation like SGS. *Id.* However, after the facility was audited by IDJJ the staff placed some additional structure into the Behavioral Plan punishment, requiring youth on a plan to attend counseling groups and completing "thinking" worksheets to reflect on the offense they had committed to be placed on the plan. *Id.* at ¶ 15. Depending on staffing levels and the preferences of staff on duty, youth were sometimes allowed to complete their paperwork in the area outside their cell or in the shared living area. *Id.* But this did not always happen—sometimes N.J. had to complete his Behavioral Plan paperwork in his cell. *Id.* Even after these changes N.J.'s experience was that youth on Behavioral Plans were confined to their rooms for more than 20 hours per day. *Id.* at ¶¶ 14-15.

85. Behavioral Hold is imposed on youth at the whim of staff. N.J. has seen youth placed on Behavioral Hold for talking back to staff, talking to a cell neighbor without authorization, passing gas, or swearing. *Id.* at ¶ 16. The length of time youth spend on Behavioral Hold is unpredictable and variable, ranging from one day to multiple days. Staff rarely explain the reason for your hold—sometimes they notify you of your Behavioral Hold by simply slapping a paper notice on your door informing you that you are on hold, but without providing explanation as to why. N.J. was placed on so many Behavioral Holds at MDH that he lost count. *Id.* at ¶¶ 17-20. He felt that between the different forms of punitive confinement he was essentially always in

solitary confinement during his most recent stay at MDH. *Id.*

86. The facility used to use the "Harvest Wing" as a place for long-term solitary confinement, which the kids called "seg." *Id.* at ¶ 22. Kids who were sent there would stay for weeks, sometimes months. *Id.* During a previous stay at the facility, N.J. remembers a 14-year-old girl being placed in the Harvest Wing. *Id.* He observed that she had serious and obvious mental health issues, and would scream constantly from the Harvest Wing. *Id.* Staff attempted to drown out her screams by running a loud fan, but it didn't really work, and her constant screaming put the other youth in the facility on edge. *Id.*

87. N.J. never attended school full-time while he was at MDH. *Id.* at ¶ 24. At no point did he have regular classes or face-to-face instruction with the one teacher at MDH. *Id.* at ¶ 25. He never used the classroom at the facility. *Id.* The schoolwork he did was just worksheets that he completed by himself in the area outside his cell. *Id.* at ¶ 26. The worksheets were never returned to him graded, and he did not get feedback from the teacher on his work. *Id.* The work was far too easy to be educationally valuable to him, especially the reading assignments. *Id.* During his final weeks at the facility he did not do any schoolwork at all. *Id.* at ¶ 24.

88. N.J. described strip searches as a common occurrence at MDH. *Id.* at ¶ 30. They were imposed both individually and as part of facility-wide strip searches. *Id.* at ¶¶ 30-31, 34. In the year-and-a-half he spent at MDH, N.J. was subjected to at least five facility-wide strip searches. *Id.* at ¶ 34.

89. In around December 2023 a writing pen went missing, so the staff conducted a facility-wide strip search. Staff went room to room conducting the searches. *Id.* at ¶ 30. Two staff members came to N.J.'s room and made him take off all his clothes, including his boxers. *Id.* The staff members told him to lift his genitals and do jumping jacks. *Id.* He refused and tried to cover

himself up because he felt very uncomfortable with the invasive process. *Id.* The staff members then left him fully naked in the cell for 30 minutes until he complied. *Id.* He felt like he had no other choice, so he eventually did the jumping jacks. *Id.* The staff members made clear that if he did not go along with the search, they would use force on him and put him on a more restricted status. *Id.* This search really bothered N.J., and the humiliation of it has stuck with him for a long time. *Id.* at ¶¶ 30-31, 34.

90. N.J. recalls another facility-wide strip search in around February 2024 that was conducted in the same way. *Id.* at ¶ 32. When kids would refuse strip searches the staff would get very rough with them. N.J. recalls seeing that when one youth initially refused to be strip searched, he was physically restrained by guards who cut his clothing from his body with a knife, and he was strip searched involuntarily. *Id.* at ¶¶ 32-33. N.J. found it very difficult and upsetting to watch. *Id.*

91. N.J. described the staff as "rough" with the kids. *Id.* at ¶ 35. During his time at MDH, N.J. saw many staff restrain kids by throwing them to the ground, using chokeholds, using riot shields, and ganging up on kids. *Id.* He had a staff member attempt to knock him unconscious by placing him in a chokehold and applying pressure to N.J.'s temple. *Id.*

92. N.J. was routinely denied access to needed medical care while at MDH. In late 2023 N.J. became extremely ill and was throwing up constantly, including vomiting blood. He had lost weight and could not keep any food down. He told many staff members about this, and all they asked him to do was "show them the blood" that he was vomiting, and if he had already flushed it down the toilet, they did nothing to help him. Even when he showed them blood, they did not get him medical attention. It took staff seven days to get N.J. any medical attention, when they eventually sent him to the hospital to be examined. *Id.* at ¶ 36.

93. During his last few months at the facility N.J. had terrible toothaches but was not allowed to see a dentist. On at least one occasion he had an appointment that was taken away from him as a punishment. He never did get to see a dentist before he was transferred. *Id.* at ¶ 37.

94. While he was locked up N.J. had suicidal thoughts often and cut himself on his chest and arms frequently. The staff knew about this and did nothing to help him, focusing instead on searching his room to find the implement he was using to harm himself. *Id.* at ¶ 39.

95. N.J. was placed on suicide watch while at MDH, though from what he could tell the only accommodation differentiating suicide watch from punitive solitary confinement was the use of rubber eating utensils inside his cell instead of plastic. He had the option to visit with a facility counselor who came to MDH a few times per week but did not find the visits helpful. *Id.* at ¶¶ 38-39.

96. N.J.'s detention at MDH has had a significant negative impact on his mental health. He felt frustrated, restless, and lonely at MDH due to the prolonged isolation and absence of human interaction. It brought out the worst in him. He felt that staff were constantly provoking him, then punishing him when he acted out, like a vicious cycle. He felt it was like a game to them to see how much he could take. *Id.* at ¶¶ 4, 11-12, 42.

97. N.J. complained about all these issues to staff many times at the facility. He has received no meaningful response or remediation. *Id.* at ¶ 41.

D. M.P.'s Experience at MDH

98. M.P. is a 15-year-old boy who was detained at MDH for about a year between April 2023 and April 2024. He was 14 when he was first detained. The facility transferred M.P. to an Illinois Department of Justice facility after he met with counsel. *See* Declaration of M.P. ("M.P. Decl."), attached hereto as Exhibit 4, at ¶¶ 1-3.

99. Like J.B.H., A.M., and N.J., M.P. was not comfortable in the small concrete cell where he spent most of his time at MDH. *Id.* at ¶¶ 5-6. He had difficulty sleeping because of the fluorescent lights that were left on for twenty-four hours per day. *Id.* at ¶ 6.

100. M.P. spent at least nineteen hours per day in his cell while he was detained at MDH—during "normal" times. *Id.* at ¶ 7. He was often in solitary confinement when he was placed on Behavioral Hold. *Id.* at ¶¶ 7-8.

101. M.P. was placed on Behavioral Hold at least twenty times while detained at MDH. *Id.* at ¶ 10. During the week he met with counsel M.P. had recently been on Behavioral Hold for three straight days for "talking back" to a staff member. *Id.* When he was on Behavioral Hold, M.P. estimated spending at least twenty-two hours per day in his room. *Id.* at ¶ 8. The time he spent outside his room was spent filling out his Behavioral Plan paperwork and participating in groups in his living area. M.P. said there were multiple kids on Behavioral Plan at any given time. *Id.* at ¶¶ 8, 10.

102. M.P. observed that when he first arrived at the facility the constant isolation that was his daily reality "really got to [him.]" *Id.* at ¶ 14. He became restless and tried to pass the time as best he could by reading, but the time felt endless. *Id.* M.P. explained that when you spend that much time in your room by yourself you get more and more angry, and then a hopelessness sets in. It is just too much time to pass. *Id.*

103. M.P. regularly observed other youth placed in more restrictive solitary confinement called SGS, which M.P. describes as constant solitary confinement. *Id.* at ¶ 11. Kids on SGS restriction basically don't leave their cells at all, they are "just isolated." *Id.* There were typically multiple kids on SGS restriction at any given time. *Id.* Some kids never seemed to leave this total isolation, and staff treated them poorly, and like they were afraid of them. *Id.*

104. When he first arrived at the facility M.P. saw staff put kids in isolation in a separate wing of MDH called the "Harvest Wing." *Id.* at ¶ 12. Soon after arriving at the facility M.P. saw a youth placed in a headlock or submission hold and dragged into the Harvest Wing, and he did not see him again for some time. *Id.* The staff stopped using the Harvest Wing as a segregation unit around June of last year—according to staff members they did this to get around a rule against using segregation units. *Id.* M.P. observed that all the staff really did, however, was move segregation unit into the youths' normal living space. *Id.*

105. M.P. did not attend anything that could be described as "school." *Id.* at ¶ 16. When he was not on Behavioral Hold, he might complete worksheets for an hour or two in the dayroom outside his cell. *Id.* The one teacher at the facility did not provide live instruction or give him feedback on his work. *Id.* M.P. did well in school outside the facility and was frustrated at MDH because the work he received there did not challenge him at all. He felt it was at a sixth-grade level at most. *Id.*

106. In or around September 2023, MDH performed a facility-wide strip search because a writing pen had gone missing at the facility. *Id.* at ¶ 18. Staff at MDH pulled each living unit into the gym, then forced the children into an empty cell one at a time for strip searches. *Id.* When they pushed M.P. into the cell the guards forced him to take off all his clothes, including his boxers. *Id.* at ¶ 19. They made him lift his genitals and do jumping jacks. They also made him squat and cough. *Id.* M.P. did not want to strip, but knew staff would force him to do it anyway so he did not feel he had any choice. *Id.*

107. M.P.'s other experiences show that he was correct to assume that staff would forcibly strip search him if he refused. *Id.* at ¶ 20. In or around December 2023 M.P. was strip searched involuntarily, again over a missing writing pen. *Id.* MDH staff brought him into an empty

cell in Lower West, where he backed up against a wall and begged staff not to strip search him. *Id.* A staff member threw M.P. down onto the cement slab bed on his stomach and pulled his legs up behind his back, twisting him into a painful position. *Id.* While that staff member was restraining him, another guard cut M.P.'s clothes and boxers off his body with a knife. *Id.* After stripping him of his clothes and forcibly searching his body, the guards left M.P. naked in the empty cell until another guard finally gave him boxers to partially cover himself. *Id.* The whole search was extremely humiliating for M.P., and being left to sit naked by himself compounded the harm. *Id.*

108. M.P. states that staff members are frequently aggressive and rough with kids at MDH, throwing them to the ground, using riot shields in cells, grabbing and tackling kids, and using headlocks. *Id.* at ¶ 22.

109. M.P. complained about all the issues above many times while at MDH and there was never any attempt to address his concerns. *Id.* at ¶ 24.

* * *

110. J.B.H., A.M., N.J., and M.P.'s experiences at MDH are not unique. They are typical of the conditions faced by all children currently detained at MDH.

111. Solitary confinement is a way of life at MDH. Children at the facility are routinely subjected to punitive solitary confinement at the whim of staff, whether it is classified as "SGS" or "Behavioral Hold"—and all children at MDH live under the threat that this traumatic punishment can be imposed on them at any time. Even when they are not subject to enhanced punishment youth spend around twenty hours per day in their cells. Many of the precious few minutes of so-called "free time" children receive outside their cells are not meaningfully different from their solitary confinement, as they spend it seated in an attached hallway only a few feet away

from their cells.

112. The youth spend their confinement in essentially identical concrete cells the size of a parking space, and have fluorescent overhead lights that never turn off, making sleep difficult to impossible. Youth are all served meals that state auditors have deemed insufficient, and that leave them hungry even after they eat. Many youth eat their meager meals alone in their cells as part of their punitive solitary confinement. Some youth in enhanced confinement have their food downgraded as part of their punishment.

113. Children at the facility—many of whom had significant mental health issues even before their incarceration—do not have access to adequate mental health services to cope with the compounding mental health traumas inflicted by their isolation and harsh physical treatment at MDH. The facility has no mental health professional on-staff. The extent of their mental health care comes from an outside social worker who visits MDH a few times a week to talk to youth, often in a non-private setting.

114. MDH routinely places children with known mental health issues—and even in acute mental health crisis—in punitive solitary confinement that serves to compound the harm they face from their inadequately treated mental illness.

115. Worse yet, the facility diminishes the minimal mental healthcare for youth in their care who are most in need. Youth placed in punitive solitary confinement have their social worker visits cut down to short, routine "check-ins" through the door of their cells that other youth can listen in on. There is no enhanced mental health intervention for children in mental health crisis, including children who are in such acute crisis that the facility has placed them on "suicide watch." To the contrary, many children on suicide watch receive diminished mental healthcare because they are simultaneously on SGS status.

116. Children at MDH are routinely subjected to humiliating, invasive, and traumatic strip searches. Many of these searches are conducted indiscriminately across the facility, without any individualized suspicion and without attempting less intrusive methods.

117. Children at MDH are routinely subjected to violence at the hands of staff, who impose harsh physical restraints on youth for relatively minor infractions.

118. Although the children in the facility are school-aged, and attended school while in the community, the facility essentially suspends their education. MDH replaces meaningful full-day schooling with—at best—educational packets and worksheets they complete mostly on their own. Youth in punitive solitary confinement have their education halted entirely.

II. The Inhumane Isolation and Strip Searches at MDH are Well-Known to Defendants

119. MDH's inhumane conditions are well known in the surrounding area and in the juvenile detention community writ large. The facility's problems are not new, they have been the subject of public scrutiny for some time, and they are well-known to Defendants.

120. In accordance with 730 ILCS 5/3-15-2(a) of the Illinois Compiled Statutes, the Illinois Department of Juvenile Justice ("IDJJ") is statutorily responsible for establishing minimum standards for juvenile detention centers throughout the state. These minimum standards include a set of regulations and guidelines that these facilities must follow and cover a broad range of areas, such as: living conditions, use of confinement, mental health services, educational services, medical care, grievance procedures, staff training and supervision, and recreation and exercise. These standards aim to create a safe, supportive, and rehabilitative environment for juveniles in detention.

121. IDJJ also conducts annual, pre-arranged physical inspections of all county detention centers to monitor compliance with these standards and to identify areas needing

improvement. 730 ILCS 5/3-15-2(b). These inspections involve evaluations of facility operations, interviews with staff and youth, and reviews of incident reports and grievance records. If a facility is found to be noncompliant with any of the standards, IDJJ notifies the facility and provides guidance on corrective actions. The results of these inspections are provided to facility personnel and are publicly available on the IDJJ's website. IDJJ's audits, conducted with ample notice and opportunity for the facility to prepare and put its best foot forward, have repeatedly found MDH seriously deficient in multiple important areas of evaluation.

122. In February 2022, IDJJ conducted its first audit of MDH and found it non-compliant in many key areas, with many significant problems "requiring immediate attention." *See* IDJJ Knox County Audit Report 2022 ("2022 Report"), attached hereto as Exhibit 5.

123. Among other serious operational failures it identified, IDJJ's 2022 Report highlighted the facility's use of extended child confinement, which it characterized as a "significant violation of several County Detention Standards." *Id.* at 7. At the time of the Department's walk-through, "most youth at the facility were confined in their rooms." *Id.* at 4. According to IDJJ, the "the utilization of confinement as a response to negative behavior at the facility is a significant concern and must be addressed urgently." *Id.* at 6. IDJJ observed that youth "are confined for eight to 32 hours for a single infraction." *Id.* It further observed that multiple youth were placed in "seg," with one youth having endured segregation for approximately six weeks, and the other for about two months. *Id.* IDJJ noted that youth in segregation had the water to their cells turned off for extended periods of time. *Id.* at 7. Youth in segregated confinement did not attend school at all, or even complete educational packets in their rooms. *Id.* One youth "had trouble communicating when she was last out of her room." *Id.* at p. 6-7.

124. IDJJ's 2022 Report also highlighted the facility's deficiencies in medical and

mental health care. It pointed out that although the facility has a part-time nurse it lacks a physician on staff, and there is no existing contract for a physician to provide services. *Id.* at 8-9. Similarly, the facility has no mental health professionals on staff; instead, it relies on a separate, outside entity called Bridgeway to provide a counselor to visit the facility for youth in crisis. *Id.* at 9. The Report concluded that "[i]t is clear that the volume of mental health services available to youth at Mary Davis Home is insufficient to meet minimum standards, much less best practice." *Id.*

125. The 2022 Report criticized the education children received at MDH. It underscored that although there is a single teacher on-site, that is insufficient educational staffing for the youth population at the facility. *Id.* at 12. Additionally, the current educator is not a licensed special education teacher, meaning youth with Individualized Education Plans ("IEPs") or other specialized education needs are not receiving necessary services. *Id.* The 2022 Report also pointed out that youth were not receiving an adequate number of hours of education per day, and those on confinement or segregation status were not receiving educational services at all. *Id.*

126. The 2022 Report also highlighted that MDH restricts certain youth from eating in the dietary area, instead requiring them to eat all their meals in their cells. *Id.* at 11-12. The food provided to youth subjected to this punishment differed or was of lesser quantity than the meals provided in the dietary. *Id.*

127. The 2022 Report also noted that strip searches were routine enough at MDH to be incorporated into the ordinary intake procedures at the facility. IDJJ therefore recommended that MDH "eliminate the use of strip searches as a standard process during intake." *Id.* at 4. Instead, strip searches could only be administered "where there is an individualized, reasonable suspicion." *Id.* at 1. This is consistent with the IDJJ's minimum standards, which explicitly limit the use of strip searches to circumstances where there is "individualized, reasonable suspicion." 20 Ill. Adm.

Code 2602.50(f).

128. IDJJ performed a follow-up audit of the facility in June 2022. MDH was the only facility that IDJJ deemed it necessary to revisit within just a few months of the original audit. The follow-up audit revealed continued failures in the areas previously identified. *See* Knox County Juvenile Detention Center—Interim Inspection Report, attached hereto as Exhibit 6.

129. Despite the clear and public warning that the 2022 Report provided, MDH continued subjecting youth to solitary confinement throughout 2022. The follow-up report highlighted multiple instances where youth were still subjected to solitary confinement as punishment; for example, one youth received confinement as punishment for having too many magazines in his cell. At least two youths were still in segregated solitary confinement in the so-called Harvest Wing while the IDJJ auditor visited the facility. IDJJ concluded that there had "been little improvement on the February findings in this area" and that Mary Davis Home "remains significantly out of compliance . . . and should take immediate action to come into compliance." *Id.* at 2.

130. The facility continued to post failing grades in education as well: it still only had one insufficiently qualified teacher available, and youth continued replacing real classroom time with passive work on packets in the dayroom area. The facility remained out of compliance with this standard. *Id.* at 3.

131. By the time of the 2022 follow-up audit, the facility still was not providing any mental health services as IDJJ required. *Id.* at 3.

132. The Department audited the facility for a third time in April 2023. *See* IDJJ Knox County Audit Report 2023 ("2023 Report"), attached hereto as Exhibit 7. The 2023 Report found that the facility was still using solitary confinement—this time over a year after the first audit

report, and after two public warnings about the practice. The Department inspector observed frequent use of confinement even while he was physically present to conduct the IDJJ audit. The 2023 Report highlighted that MDH regularly rotates youth "in and out of confinement throughout the day with no behavioral justification." *Id.* at 4-5. In addition, the 2023 Report characterized the facility's use of punitive confinement as being "used excessively as a behavioral consequence." *Id.* at 5. The 2023 Report observed that MDH re-branded its punitive confinement practice with the term "Behavior Hold," but the practice still involved confining youth to their cells for 24 hours or more. *Id.*. The 2023 Report highlighted one instance where a youth had been placed on a behavioral hold the day before the inspection and remained on hold during the inspection. *Id.* This youth's parental visit was cancelled as part of this punishment in violation of detention standards. *Id.* There were still two youth segregated in the Harvest Wing at the time of the audit. *Id.*

133. The 2023 Report also highlighted issues with the use of physical restraint at the facility. *Id.* at 6. The auditor reviewed recent video footage of one physical restraint incident at MDH and deemed it necessary to report it to the Department of Children and Family Services. *Id.* Additionally, it was noted that the staff member involved in the restraint incident had not received proper restraint training. *Id.*

134. The 2023 Report acknowledged that the facility had hired a part-time physician, but MDH still failed to meet standards for providing adequate mental health care. *Id.* at 6-7. The 2023 Report observed that the facility had arranged for an outside social worker to visit twice a week for a total of seven hours of weekly services, but her role primarily involved assessing day-to-day needs. *Id.* at 7. Due to limited hours, the social worker had not conducted assessments on all youth at the facility. *Id.* Additionally, the social worker did not have a formal caseload and did not develop treatment plans. *Id.*

135. At the time of the 2023 audit the facility still had only one general education teacher and no special education teacher at all. *Id.* at 8. The 2023 Report noted that MDH's lone teacher was not even licensed to teach high school, being licensed only for grades K-9. *Id.* The 2023 Report observed that the facility continued to make insufficient use of the classroom and relied on packets instead of instruction. *Id.*

136. The Department audited the facility for a fourth time in February 2024. *See* IDJJ Knox County Audit Report 2024 ("2024 Report"), attached hereto as Exhibit 8. This audit again found MDH non-compliant in the use of confinement and in provision of education to youth in the facility. *Id.* at 1. The audit highlighted two forms of punitive confinement: SGS and "behavior hold". It noted that youth are often kept on SGS for multiple days, and "both youth and staff report[ed] a significant amount of confinement associated with" both SGS and Behavioral Plan, and particularly for SGS. *Id.* at 4. The 2024 Report observed that children not on these punitive statuses were "frequently . . . confined unnecessarily" throughout the day. *Id.* Several youth reported to the auditor that they only come out of their cells for "dinner recreation time." *Id.* at 5.

137. The 2024 Report also underscored the persistent educational shortcomings at MDH, echoing findings from prior audits. Despite these prior warnings, MDH still only has one teacher and no special education teacher. *Id.* at 6. The only teacher at MDH is only certified to teach grades K-9, and is not licensed to instruct high school students. *Id.* The audit report highlighted that MDH's only classroom's capacity is limited to 12 students at a time, despite the facility housing more than 12 children. *See id.* Any additional youth are given educational packets and must complete them in another part of the facility. *Id.*

138. Regarding mental health care, the 2024 Report noted that while a mental health counselor is available at the facility a few times a week, "youth on SGS are almost always confined

when the MHP meets with them" and that "[the MHP] has little to do with the implementation of the SGS plan itself." *Id.* at 5.

139. The Administrative Office of Illinois Courts ("AOIC"), through its Probation Services Division, has also established its own policies and standards for juvenile detention centers, focusing on the quality of care and services provided to detained youth. *See* 730 ILCS 110/15(1). To ensure compliance with these standards, the AOIC conducts site visits at juvenile detention centers every two years. AOIC provides a report to facility staff with recommendations and required changes. Copies of these reports are also posted on the AOIC website. In July 2022, the AOIC audited MDH and found that the facility failed to meet the criteria in all nine areas audited (Introduction, Administration, Admissions, Programming, Medical and Mental Health Services, Release Planning, Documentation, Resident Rights). In each category, MDH received a "Does Not Meet" rating, which is the lowest possible rating among the options: Exceeds, Meets, Meets with Recommendations, and Does Not Meet. *See* AOIC Summary of the Juvenile Detention Review: Mary Davis Home 2022, attached hereto as Exhibit 9.

140. A third state agency, the Illinois State Board of Education ("ISBE"), conducted an audit of MDH in May 2023 to review its nutrition program and meal compliance. *See* ISBE School Nutrition Programs Meal Compliance and Accountability Report 2023, attached hereto as Exhibit 10. In its final report, ISBE noted that "due to the severity of the problems identified, County of Knox [MDH] will receive a follow-up review." *Id.* The report highlighted several critical issues, including inadequate portion sizes in meal services, food safety and storage problems, and deficiencies in food documentation. *See id.*

III. The Conditions at MDH Are a Direct Result of Policies, Customs, and Practices Defendants Developed

141. MDH's culture of solitary confinement, unmitigated by mental health resources or

meaningful educational opportunity, has developed as a consistent and deliberate policy, custom, and practice over an extended period of time under the leadership of Defendants Cavanaugh, Steck, and Pletz, who are responsible for overseeing the day-to-day operation of the facility, and under the oversight of Knox County, which is the final policymaking authority for the Center and exercises hiring authority and oversight over the other Defendants with respect to the facility's functioning. Defendants have subjected children to these conditions with no legitimate penological government purpose, and in the face of public condemnation of the facility's practices.

142. The unconstitutional conditions children experience at MDH are also a direct result of a policy of inadequate staffing and deprivation of key resources that has been established by the Knox County Board, and overseen and implemented by Defendants Cavanaugh, Steck, and Pletz. Knox County has a statutory duty to "support[] and maintain" a juvenile detention center, including paying for the costs of "its establishment and maintenance" and for "supplies or repairs necessary to maintain, operate and conduct . . . the detention home" and detention services. *See* 55 ILCS 75/1(a); 55 ILCS 75/3(a)-(d); 55 ILCS 75/9.3. It has failed to do so.

IV. The Conditions and Culture of Solitary Confinement Maintained at MDH are Profoundly Harmful

A. Extended Solitary Confinement is Harmful for Children

143. An extensive body of research on solitary confinement establishes that the practice results in serious and wide-ranging negative effects on incarcerated individuals. Children are particularly vulnerable to the harmful effects of confinement due to their ongoing physical, psychological, social, and neurological development. As a result, there is a widespread clinical consensus that solitary confinement is inappropriate for children. *See* Declaration of Louis Kraus, M.D. ("Kraus Decl."), attached hereto as Exhibit 11.

144. Children who have a history of trauma, mental illness, or developmental disabilities

are particularly vulnerable to the harms caused by solitary confinement. *Id.* at ¶¶ 19, 24. Most children who are detained or incarcerated for any length of time fall into one or more of these categories. *Id.*

145. Children in solitary confinement face a significant risk of serious psychological and emotional harm. *Id.* at ¶¶ 15-16, 18. Solitary confinement negatively impacts children by perpetuating or worsening existing mental health problems, or precipitating new ones. *Id.* at ¶ 20. This can lead to a range of psychological symptoms, including but not limited to, anxiety, depression, difficulty maintaining attention, impaired concentration, memory problems, disorientation, heightened sensitivity, feelings of paranoia and psychosis, engaging in self-harm, and an increased risk of suicide. *See id.* at ¶¶ 26-27.

146. The effects of solitary confinement manifest in physical symptoms, including gastrointestinal problems, insomnia, deterioration of eyesight, chronic fatigue, weakness, sensitivity to cold temperatures, heart palpitations, recurring migraine headaches, joint pains, loss of appetite, weight loss, and exacerbation of pre-existing medical conditions. *See id.* at ¶ 28.

147. Solitary confinement deprives children of social interaction, educational opportunities, and environmental stimulation during critical developmental stages. Children subjected to this practice see their cognitive growth and overall brain development severely impaired. *See id.* ¶ 20.

148. Because it necessarily deprives them of educational opportunities, extended solitary confinement also deprives children of the intellectual stimulation needed for their cognitive development. *See id.* at ¶ 30; *see also* Sandra Simkins, Marty Beyer, and Lisa Geis, *The Harmful Use of Isolation in Juvenile Facilities: The Need for Post-Disposition Representation*, 38 WASH. U.J.L. & POL'Y 241, 257-61 (2012); *see also Report of the Attorney General's National Task Force*

on Children Exposed to Violence, U.S. Department of Justice Office of Juvenile Justice and Delinquency Prevention (December 2012), https://www.justice.gov/defendingchildhood/cev-rpt-full.pdf.

149. Suicide rates and incidents of self-harm are much higher for detainees in solitary confinement. *See id.* ¶¶ 22-23*; see also* ACLU Briefing Paper, *The Dangerous Overuse of Solitary Confinement in the United States* (2014), https://www.aclu.org/sites/default/files/assets/stop_solitary_briefing_paper_updated_august_2014.pdf. A national study by the U.S. Department of Justice Office of Juvenile Justice and Prevention found that half of youth who committed suicide in juvenile facilities were in isolation at the time of their death and more than 60% percent of young people who committed suicide in detention had a history of being held in isolation. *Id.* ¶ 22; Lindsay Hayes, *Juvenile Suicide in Confinement: A National Survey*, U.S. Department of Justice Office of Justice Programs (February 2009), https://www.ojp.gov/pdffiles1/ojjdp/213691.pdf. Among children held in detention centers, 40% of suicides occurred within the initial 72 hours of confinement. Kraus Decl. at ¶ 22. Thus, even short periods of solitary confinement pose a serious risk of harm that can be fatal for children. *Id.*.

150. Children subjected to solitary confinement have an increased chance of recidivism, or reoffending. *Id.* at ¶ 28; Council of Juvenile Correctional Administrators, *CJCA Toolkit: Reducing the Use of Isolation* (March 2015), https://stopsolitaryforkids.org/wp-content/uploads/2016/04/CJCA-Toolkit-Reducing-the-use-of-Isolation.pdf. Isolation and a lack of rehabilitative programming can make successful reintegration into society more difficult. *See id.* at ¶ 25, 30. Additionally, the psychological trauma caused by solitary confinement can lead to feelings of alienation from society and resentment, reducing defined children's ability to reintegrate into their communities and making it more difficult for them to find stability. *See id.* at

¶ 17-18, 20, 25.

151. The negative effects of solitary confinement can extend beyond the immediate period of isolation. Children may continue to experience the negative effects of solitary confinement even after their release from custody. *Id.* at ¶ 24.

152. The overwhelming body of research demonstrating youth solitary confinement's profound harms has led to a widespread legal and institutional consensus that the practice has no proper place in juvenile detention. In December 2012, a task force appointed by the U.S. Department of Justice's Attorney General issued a report that read in part, "[n]owhere is the damaging impact of incarceration on vulnerable children more obvious than when it involves solitary confinement." *Report of the Attorney General's National Task Force on Children Exposed to Violence,* U.S. Department of Justice Office of Juvenile Justice and Delinquency Prevention (December 2012), https://www.justice.gov/defendingchildhood/cev-rpt-full.pdf. And in 2016, based on the Department's recommendation, the use of solitary confinement against children was banned in all federal prisons. *Department of Justice Review of Solitary Confinement*, The White House Office of the Press Secretary (January 2016), https://obamawhitehouse.archives.gov/the-press-office/2016/01/25/fact-sheet-department-justice-review-solitary-confinement.

153. Other authorities such as the American Medical Association, the American Academy of Child and Adolescent Psychiatry, and the National Commission on Correctional Health Care have recognized that solitary confinement is harmful for children and have opposed the use of solitary confinement on children. Kraus Decl. at ¶ 28.

154. International and human rights organizations have also criticized the use of solitary confinement. The World Health Organization ("WHO"), the United Nations, and other international bodies have recognized that solitary confinement is particularly harmful to a child's

psychological well-being and cognitive development. The United Nations Standard Minimum Rules for the Treatment of Prisoners, revised in 2015 as the Nelson Mandela Rules, completely prohibit solitary confinement for children. *Resolution adopted by the General Assembly on 17 December 2015*, United Nations General Assembly (January 2016), https://documents-dds-ny.un.org/doc/UNDOC/GEN/N15/443/41/PDF/N1544341.pdf?OpenElement. The United Nation's Special Rapporteur on Torture has repeatedly condemned the use of solitary confinement on children *for any duration*, calling it "cruel, inhuman or degrading treatment or punishment or even torture." *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, United Nations General Assembly (2015), file:///C:/Users/apicard/Downloads/A_HRC_28_68_Add.1-EN.pdf.

155. In Illinois's youth prison system solitary confinement has been effectively banned for some time. On May 4, 2014, as part of a lawsuit filed in 2012 by the ACLU of Illinois, IDJJ instituted a policy banning use of the practice in its now five state-run juvenile facilities. *R.J. v. Mueller*, No. 12 C 7289 (N.D. Ill. Sept. 2012); *see also* Julie Bosman, *Lawsuit Leads to New Limits on Solitary Confinement at Juvenile Prisons in Illinois*, The New York Times (2015), https://www.nytimes.com/2015/05/05/us/politics/lawsuit-leads-to-new-limits-on-solitary-confinement-at-juvenile-prisons-in-illinois.html.

156. In addition, in May 2023 the Illinois House and Senate passed Illinois House Bill 3140, also known as the "End Youth Solitary Confinement Act," which restricts youth solitary confinement in juvenile detention centers. (Public Act 103-0178). The new law went into effect on January 1, 2024. Defendants Pletz and Steck both filed witness slips in opposition to the

proposed bill.[1]

157. Many other states in recent years have banned or placed restrictions on the use of solitary confinement for children as well. *See, e.g.*, Amy Fettig, *2019 was a Watershed Year in the Movement to Stop Solitary Confinement*, ACLU National Prison Project (December 2019); *see also State Laws or Rules that Limit or Prohibit Solitary Confinement of Juveniles*, National Conference of State Legislatures (January 2021), https://www.documentcloud.org/documents/21203238-state-laws-that-limit-or-prohibit-solitary-confinement-2020.

B. Defendants Confine Children in Physical Conditions That Create a Psychologically Abusive Environment

158. MDH compounds the harm caused by its use of solitary confinement with the conditions of the cells themselves.

159. Fluorescent overhead lights in children's cells stay on 24 hours a day. Sleeping in a constantly illuminated environment has been shown to be extremely harmful. Indeed, it is a recognized method of torture. *Solitary Confinement Facts*, American Friends Service Committee, https://afsc.org/solitary-confinement-facts; *see also Torture in United States Prisons: Evidence of Human Rights Violations*, American Friends Service Committee, https://afsc.org/sites/default/files/documents/torture_in_us_prisons.pdf.

160. MDH further disrupts children's sleep by denying them pillows and adequate blankets.

161. When they are occasionally allowed to leave their cells, children are still prevented from contacting other children, even those locked up in cells only a few feet away. They are also

[1] Witness Slips For HB3140, 103rd General Assembly, https://www.ilga.gov/legislation/Witnessslip.asp?LegDocId=184864&DocNum=3140&DocTypeID=HB&LegID=&GAID=17&SessionID=112&GA=103&SpecSess=&Session=&WSType=OPP.

subjected to invasive strip searches and other traumatic and physically abusive encounters with staff and sometimes with law enforcement officers, who are frequently called in to supplement the staff on site at MDH.

162. In addition, children are frequently left hungry, with inadequate food that lacks the necessary calories and nutrients to meet basic nutritional standards. Youth in punitive confinement have their already inadequate food rations downgraded as part of their punishment.

163. All of these conditions reinforce one another to form a toxic, abusive, and unconstitutional environment no child should be made to endure.

C. Withholding Mental Healthcare from Youth Subjected to Extended Solitary Confinement is Harmful

164. The culture and policy of solitary confinement maintained at MDH imposes harms that are amplified by Defendants' cruel failure to provide the affected children with mental health services necessary to cope with the trauma of their surroundings.

165. A large percentage of children in detention have diagnosed and undiagnosed mental health needs, or histories of trauma and abuse, or both. *See* Kraus Decl. at ¶¶ 19-20. A national study found that 75% to 93% of children entering the juvenile justice system are estimated to have experienced some degree of trauma. Samantha Buckingham, *Trauma Informed Juvenile Justice*, 53 Am. Crim. L. Rev. 641, 654 (2016).

166. Additionally, studies show that 65-75% of children in juvenile custody have a diagnosable mental health disorder, with 20% of these children exhibiting a severe mental health disorder. *See* Skowyra, Kathleen, and Cocozza, Joseph., *A Blueprint for Change: Improving the System Response to Youth with Mental Health Needs Involved with the Juvenile Justice System*, The National Center for Mental Health and Juvenile Justice Policy Research Associates, Inc. (January 2007). MDH's practice of solitary confinement exacerbates these mental health problems

while causing new ones. *See* Kraus Decl. at ¶ 20.

167. MDH routinely subjects youth the facility knows to suffer mental health issues, including youth in acute mental health crisis and/or on "suicide watch," to punitive solitary confinement.

168. Withholding mental healthcare from youth subjected to solitary confinement—even those on suicide watch or otherwise acute mental health crisis—exacerbates the practice's physical and psychological harms and inflicts new ones. *See* Kraus Decl. at ¶ 23.

D. Withholding Education from Youth Subjected to Extended Solitary Confinement is Harmful

169. Defendants' failure to provide the children in their care a meaningful education further compounds the harm of their solitary confinement.

170. It is well-established that education in correctional facilities reduces recidivism rates. Davis, Lois M., Robert Bozick, Jennifer L. Steele, Jessica Saunders, and Jeremy N. V. Miles, *Evaluating the Effectiveness of Correctional Education: A Meta-Analysis of Programs That Provide Education to Incarcerated Adults*, RAND Corporation (2013), https://www.rand.org/pubs/research_reports/RR266.html. Defendants have failed to ensure that all children detained at MDH have access to meaningful and comprehensive educational services.

171. Children at the facility are formally enrolled at the local Galesburg, Illinois school district. The Regional Office of Education employs one primary teacher, but none of the children at MDH are receiving full-time educational services.

172. As IDJJ's Reports noted, the children at MDH do not consistently attend school in a classroom. Their experience with "schooling" was often the completion of self-guided worksheets. There is no qualified and licensed special education teacher on staff, and no special education services provided to children with Individualized Education Plans. There is no full-day

school for any of the youth at MDH, and youth in punitive solitary confinement are denied access to schoolwork altogether. School is constantly canceled or denied as punishment throughout the facility, or in response to even slight disruptions or time conflicts.

173. Children incarcerated at MDH are at crucial points in their educational development. Outside incarceration, cancellation of a single day of school causes these youths' school districts to mobilize and plan to make up every lost hour at the end of the year. Yet when they enter MDH, their educational needs are simply ignored, sometimes for weeks or months. They are thus deprived of education as punishment, and denied the education provided to other children their age in Illinois.

174. As a proximate result of the Defendants' repeated failures to provide an adequate education to children in their custody, the children in MDH suffer compounding physical and psychological harm from their confinement, and are falling behind in their academic development.

E. Defendants' Practice of Conducting Mass Strip Searches of Children Causes Serious Psychological Harm

175. Just as prolonged isolation causes psychological damage to youth incarcerated at MDH, the facility's frequent use of mass strip searches likewise causes serious harm.

176. Strip searches involving visual inspection of a person's anal and genital areas are inherently "demeaning, dehumanizing, undignified, humiliating, terrifying, unpleasant, embarrassing, repulsive, signifying degradation and submission." *Henry v. Hulett*, 969 F.3d 769, 778 (7th Cir. 2020) (*citing* Mary Beth G. v. City of Chicago, 723 F.2d 1263, 1272 (7th Cir. 1983)). But these incredibly serious invasions of privacy are even more traumatic for children, whose brains are still developing. *See* Kraus Decl. at ¶ 30; *see also Eddings v. Oklahoma*, 455 U.S. 104, 115 (1982) ("Youth is more than a chronological fact. It is a time and condition of life when a person may be most susceptible to influence and to psychological damage.")

177. As the Seventh Circuit has recognized, "[i]t does not require a constitutional scholar to conclude that a nude search of a thirteen-year-old child is an invasion of constitutional rights of some magnitude. More than that: it is a violation of any known principle of human decency." *Doe v. Renfrow*, 631 F.2d 91, 92–93 (7th Cir. 1980); *see also N.G. v. Connecticut*, 382 F.3d 225 (2d Cir. 2004) (explaining that courts "should be especially wary of strip searches of children" and holding that group strip searches based on missing pencil required reasonable suspicion after less intrusive searches were conducted).

178. The experience of a strip search can cause emotional consequences that endure long after the search is completed. *See* Kraus Decl. at ¶ 30. Youth may experience anxiety, depression, loss of concentration, sleep disturbances, difficulty performing in school, phobic reactions, shame, guilt, depression, and other lasting emotional scars. *Addressing Trauma: Eliminating Strip Searches*, JUV. L. CTR. (June 1, 2017), https://jlc.org/sites/default/files/attachments/2020-04/AddressingTraumaEliminatingStripSearch%20March%202020.pdf. Strip searches can also retraumatize youth who are survivors of sexual abuse. *Id.* The trauma from these kinds of invasive procedures can result in lasting consequences into adulthood.

CLASS ALLEGATIONS

179. Plaintiffs J.B.H. and A.M. bring this action on their own behalf and on behalf of others similarly situated pursuant to Rules 23(a) and 23(b)(2) of the Federal Rules of Civil Procedure.

180. The putative Plaintiff Class includes all children who are currently, or in the future will be, detained in MDH (the "Putative Class").

181. The "Putative Class" consists of children detained pretrial and awaiting release or transfer to their permanent detention facility, which constitutes an inherently transitory population.

While there is uncertainty as to how long any one plaintiff will remain at MDH, there will be a constant class of youth suffering the constitutional violations alleged in this Complaint as long as MDH remains in operation.

182. If discovery or further investigation reveals that the Putative Class should be expanded or otherwise modified, the named Plaintiffs reserve their right to amend the Class definition or propose subclasses as necessary.

183. The Plaintiff Putative Class satisfies the requirements of Rule 23(a) in that:

184. *Numerosity*: The Putative Class is so numerous that joinder of all members is impracticable. MDH detains hundreds of children annually. According to the most recent available data, MDH had 199 admissions in 2023.[2] There has been similarly significant facility turnover in 2023. Due to financial and legal capacity constraints, most of these children cannot file individual lawsuits.

185. *Commonality*: There are questions of law and fact common to the Putative Class. These include, but are not limited to:

(a) Whether the conditions at MDH pose substantial risks of serious harm to Plaintiff and the Class?

(b) Whether the State Defendants knew or should have known of these risks?

(c) Whether the County's long-standing "policy or custom" of understaffing the Center caused harmful and injurious conditions at MDH?

(d) Whether Defendants' policy or practice of unreasonable strip searches caused harmful and injurious conditions at MDH?

186. *Typicality*: The named Plaintiffs' claims are typical of those of the Putative Class. The named Plaintiffs are detained at MDH and have been subjected to the Defendants' challenged

[2] *JMIS Monthly Data Report*, ILLINOIS JUVENILE JUSTICE COMMISSION (2023), https://ijjc.illinois.gov/wp-content/uploads/2024/02/JMIS-Monthly-Data-Report-December.pdf.

policies, practices, and procedures (or lack thereof); therefore, their claims arise from the same conduct and are based on the same legal theory as the class claims.

187. *Adequacy*: The named Plaintiffs are capable of fairly and adequately protecting the interests of the Putative Class and will diligently serve as class representatives. The named Plaintiffs do not have any antagonistic interests to the Putative Class and seek injunctive relief on a class-wide basis to remedy class injuries and enjoin the Defendants' unlawful conduct. Furthermore, the named Plaintiffs and the Putative Class are represented by competent counsel with significant experience in civil rights litigation, detainee and prisoners' rights litigation (including over a decade of experience in the youth detention context in Illinois), and complex class action litigation.

188. This action is maintainable as a class action pursuant to Rule 23(b)(1) because the prosecution of separate actions by individual children would create a risk of inconsistent and varying adjudications, which in turn, would establish incompatible standards of conduct for MDH.

189. This action is also maintainable as a class action pursuant to Rule 23(b)(2) because Defendants have acted, or failed to act, on grounds generally applicable to the Class as a whole, and the injunctive and declaratory relief sought is appropriate and will apply to all members of the Class.

CAUSES OF ACTION

COUNT I – 42 U.S.C. § 1983
Violation of the Fourteenth Amendment
(Asserted by Named Plaintiff and Putative Class Against Defendants Chief Judge Raymond Cavanaugh, Bridget Pletz, and Wendi Steck)

190. The preceding paragraphs are incorporated as if fully set forth herein.

191. Plaintiffs and members of the Putative Class have substantive Due Process rights to humane conditions of confinement, that include, but are not limited to: the right to be free from

and protected from physical, psychological, and emotional harm; the right to necessary treatment, care, and services; the right not to deteriorate physically, psychologically, or emotionally while in custody; and the right to be free from substantial risks of the above-mentioned harms.

192. Defendants maintain a policy, custom, and practice of using solitary confinement as a form of punishment for children at MDH, whether through SGS or Behavioral Plans. These forms of punitive confinement lack any discernible penological or governmental purpose and starkly contradict established clinical and legal consensus, which deems youth solitary confinement profoundly harmful.

193. Defendants compound the harm of solitary confinement by not providing adequate mental healthcare services for children in their custody. They routinely place youth they know to have mental illness, including youth in acute mental health crisis, in punitive solitary confinement. They provide insufficient mental health care to children in solitary confinement despite the heightened risks associated with their isolation. Children on SGS or suicide watch, or children who are simultaneously on both statuses, often endure prolonged confinement without meaningful mental health interventions.

194. Defendants further compound the harm to children detained at MDH by denying them any meaningful education at critical points in their academic development.

195. Children at MDH thus endure a constellation of abuses and deprivations while detained there. They are locked in extended solitary confinement in brightly-lit cells that make normal sleep difficult to impossible and eliminate the possibility of sufficient physical exercise. This is all inflicted while the youth are denied basic mental healthcare and the intellectual stimulation that comes from age-appropriate schooling.

196. These practices—each harmful in isolation—mutually reinforce and amplify one

another to create an environment of acute psychological abuse at MDH. They deprive children of their human needs for regular exercise, fresh air, adequate nutrition, sufficient sleep, and meaningful social connection, all of which are essential for children whose brains and bodies are still developing.

197. These conditions are imposed on children as punishment, and with no legitimate government or penological purpose.

198. Defendants are aware of the harm and risks of harm these practices cause to children at MDH, yet have consistently applied the same harmful policies and practices and failed to make meaningful changes to improve the conditions at MDH. The Defendants' response to this harm and risk of harm is objectively unreasonable and shows a deliberate, knowing, or reckless disregard for the consequences of the conditions at MDH.

199. Defendants' actions were taken under color of state law and within the scope of their employment.

200. Defendant Cavanaugh's actions challenged in this Complaint were administrative rather than judicial in nature.

201. The conditions described in this Complaint violate the Due Process rights of the children detained at MDH.

202. Defendants have continuously violated the law, as detailed in this Complaint. As a proximate result of Defendants' actions, the named Plaintiffs, as well as the Putative Class they represent, have endured and continue to suffer serious and irreparable physical, psychological, and emotional injuries.

203. These injuries will continue unless enjoined by this Court.

COUNT II – 42 U.S.C. § 1983
Violation of the Eighth and Fourteenth Amendments
(Asserted by Named Plaintiff and Putative Class Against Defendants Chief Judge Raymond Cavanaugh, Bridget Pletz, and Wendi Steck)

204. The preceding paragraphs are incorporated as if fully set forth herein.

205. Defendants know that the children in their custody frequently enter the facility with serious mental health conditions and prior trauma. Despite knowing of the vulnerable nature of this population, Defendants maintain a policy, custom, and practice of using solitary confinement as a form of punishment for children at MDH, whether through SGS or Behavioral Plans. These forms of punitive confinement lack any discernible penological or governmental purpose and starkly contradict established clinical and legal consensus, which deems youth solitary confinement profoundly harmful.

206. Defendants compound the harm of solitary confinement by not providing adequate mental healthcare services for children in their custody. They routinely place youth they know to have mental illness, including youth in acute mental health crisis, in punitive solitary confinement. They provide insufficient mental health care to children in solitary confinement despite the heightened risks associated with their isolation. Children on SGS or suicide watch, or children who are simultaneously on both statuses, often endure prolonged confinement without meaningful mental health interventions.

207. Defendants further compound the harm to children detained at MDH by denying them any meaningful education at critical points in their academic development.

208. Children at MDH thus endure a constellation of abuses and deprivations while detained there. They are locked in extended solitary confinement in brightly-lit cells that make normal sleep difficult to impossible and eliminate the possibility of sufficient physical exercise. This is all inflicted while the youth are denied basic mental healthcare and the intellectual

stimulation that comes from age-appropriate schooling.

209. These practices—each harmful in isolation—mutually reinforce and amplify one another to create an environment of acute psychological abuse at MDH. They deprive children of their human needs for regular exercise, fresh air, adequate nutrition, sufficient sleep, and meaningful social connection, all of which are essential for children whose brains and bodies are still developing.

210. These conditions are imposed on children as punishment, and with no legitimate government or penological purpose.

211. Defendants have been repeatedly informed of the harm caused by their actions to children detained at MDH, as well as the severe damage inflicted upon children in their care due to the conditions at MDH. Despite this awareness, Defendants are deliberately indifferent to the harm and risks of harm these practices cause to children at MDH, and have consistently acted with deliberate indifference by applying the same harmful policies and practices and failing to make any changes to improve the conditions at MDH.

212. Plaintiff and members of the Putative Class have Eighth Amendment rights that include, but are not limited to: the right to be free from and protected from physical, psychological, and emotional harm; the right to necessary treatment, care, and services; the right not to deteriorate physically, psychologically, or emotionally while in custody; and the right to be free from substantial risks of the above-mentioned harms.

213. The conditions described in this Complaint violate the Eighth and Fourteenth Amendment rights of the children detained at MDH.

214. Defendants have continuously violated the law, as detailed in this Complaint. As a proximate result of Defendants' actions, the named Plaintiff, as well as the Putative Class he

represents, have endured and continue to suffer serious and irreparable physical, psychological, and emotional injuries; they likewise face a substantial risk of serious injuries from Defendants' persistent and ongoing violations of the law.

215. These injuries will continue unless enjoined by this Court.

COUNT III – 42 U.S.C. § 1983
Municipal Liability
(Asserted by Named Plaintiff and Putative Class Against Defendant Knox County)

216. The preceding paragraphs are incorporated as if fully set forth herein.

217. Defendant Knox County, acting through the Knox County Board, is the final policymaking authority for MDH. It is responsible for overseeing MDH's operation and supervising and conferring with its leadership, funding MDH's operations, as well as hiring staff and contracting for support services that shape the day-to-day lives of the children at MDH.

218. Knox County implemented and oversaw the policy, custom, and practice of children being subjected to solitary confinement in substandard conditions without access to mental healthcare or a meaningful education.

219. The County has also overseen and participated in a pattern and practice of constitutional violations so widespread as to constitute a custom, policy, or practice with the force of law.

220. Defendant Knox County reasonably knew that its failure adequately to staff the facility would result in children being subjected to a harmful mental health environment, while confined to their cells and without access to critical services like education and medical and mental health care.

221. Defendant Knox County was also made aware that its policies, practices, and customs caused the unconstitutional conditions described in this Complaint, and of the attendant

harm they caused the children of MDH.

222. Defendant Knox County's policies, practices, and procedures proximately caused the harm described in this Complaint.

223. Defendant Knox County acted with deliberate indifference in developing, overseeing, and implementing those policies, customs, and practices.

224. Defendant Knox County's actions are not only objectively unreasonable, but also show a deliberate disregard for the consequences.

225. Defendant Knox County has continued to violate the Constitution, and the named Plaintiff, as well as the Putative Class he represents, have endured and continue to suffer serious and irreparable physical, psychological, and emotional injuries and risks of injuries as a result.

226. These injuries will continue unless enjoined by this Court.

COUNT IV – 42 U.S.C. § 1983
Violation of the Fourth and Fourteenth Amendments
(Asserted by Named Plaintiff and Putative Class Against Defendants Chief Judge Raymond Cavanaugh, Bridget Pletz, and Wendi Steck)

227. The preceding paragraphs are incorporated as if fully set forth herein.

228. Defendants maintain a policy or practice of conducting frequent and unreasonable mass strip searches of the children confined at MDH, in violation of the Fourth and Fourteenth Amendments.

229. These searches are overly broad in scope, as they are conducted as mass strip searches of all youth in the facility, without any individualized suspicion or reasonably articulable security interest.

230. The searches are highly and disproportionately invasive. Strip searching is an unreasonable method of searching children absent evidence of an imminent risk of harm.

231. Defendants have continuously violated federal law, as detailed in this Complaint.

As a proximate result of Defendants' actions, the named Plaintiff, as well as the Putative Class he represents, have endured and continue to suffer serious and irreparable physical, psychological, and emotional injuries, and have been and continue to be subject to substantial risk of continued harm.

232. These injuries will continue unless enjoined by this Court.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs J.B.H. and A.M., on behalf of themselves and all others similarly situated, respectfully request that the Court enter the following relief:

a. Declare this suit is maintainable as a class action pursuant to Rules 23(a), 23(b)(1) and 23(b)(2) of the Federal Rules of Civil Procedure;

b. Adjudge and declare pursuant to Rule 57 of the Federal Rules of Civil Procedure that the conditions of confinement at MDH, as well as the Defendants' policies, practices, acts, and omissions complained of herein, violate the rights of the named Plaintiffs and the Putative Class they represent under the Eighth Amendment, Fourth Amendment, and Fourteenth Amendments.

c. Permanently enjoin Defendants, their agents, officials, employees, and all persons acting in concert with them under color of state law or otherwise, from continuing the unlawful acts, conditions, and practices described in this Complaint;

d. Order Defendants, their agents, officials, employees, and all persons acting in concert with them under color of state law or otherwise, to develop and implement, as soon as practical, a plan to eliminate the substantial risks of serious harm described herein;

e. Award named Plaintiffs and the Class attorneys' fees, costs, and expenses pursuant to 42 U.S.C. § 1988; and

f. Grant such other and further relief and this Court deems just and proper.

DATED: June 11, 2024

Respectfully submitted,

/s/ Kevin M. Fee

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Exhibit 1

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS

J.B.H., by his next friend Debra Medlock, and A.M., by his next friend Rachael Puig, on behalf of themselves and all others similarly situated, Plaintiffs, v. KNOX COUNTY, CHIEF JUDGE RAYMOND A. CAVANAUGH of the Ninth Judicial Circuit Court, BRIDGET E. PLETZ, Director of Court Services of the Ninth Judicial Circuit Court, and WENDI L. STECK, Superintendent of the Mary Davis Home, Defendants.	)	Case No. 4:24-cv-04096-JES-JEH Hon. Judge James E. Shadid

AMENDED DECLARATION OF J.B.H.

I, J[redacted] B[redacted]-H[redacted], pursuant to 28 U.S.C. § 1746, declare as follows:

1. I have been detained at Mary Davis Home ("MDH" or "Mary Davis") since around March 29, 2024. I am 17 years old.

2. This is my fifth time being detained at MDH. The first time lasted for three weeks in December 2021, and the second was for approximately two months in early 2022. The third time was for around a month in April 2022, and the fourth was in late 2022.

3. In addition to my time at MDH, I've also been detained at Focus House and the Illinois Department of Juvenile Justice.

4. MDH has four wings: Upper West, Lower West, Upper East, and Lower East. Right now, I'm in Lower East. During my previous stays, I've been on all the other wings too. All the cells are the same: they are concrete boxes about the size of a parking space with barely enough

room to move around. They have a concrete slab with a thin mattress along one wall, and a combined sink and toilet. There are 3 other kids on my wing.

5. During my previous stays at the facility, MDH had the "Harvest Wing" in operation. The Harvest Wing is a separate living wing just for segregation—full-time confinement and isolation. Although I've never been sent to the Harvest Wing myself, I have seen other kids being sent there. I heard from staff that they stopped using the Harvest Wing because the State told them they had to, but they just moved solitary confinement to the normal living areas instead.

6. For the past several weeks, I've been on 23 and 1. This means I'm confined to my cell for 23 hours each day, with only 1 hour allowed out—usually for making phone calls and sometimes recreation. I eat all of my meals in my cell. I'm in my cell for extended periods because I'm on what the staff calls "Special Group Status" or "SGS," which is one of the ways staff discipline kids here. It just means you're in solitary confinement basically all day every day.

7. You can get put on SGS for a lot of things, like cussing or fighting. I was put on SGS this last time because I refused to go back into my cell when staff was messing with my medication. The staff nurse tried to give me my medication while I was eating in the area between the cells, but I told her I wanted to wait until I finished my meal. The nurse insisted I take my medication immediately, but I wanted to wait until I had a full stomach. When she said she was going to mark it as a refusal to take my meds, it made me upset and I argued with her. The staff at MDH didn't like that and forced me to go back to my cell before I finished eating or received my medication. When I came out of my cell the next time, the nurse didn't give me my medication at all, which upset me even more. The staff then physically grabbed and restrained me, forced me into my cell, and placed me on SGS.

8. I don't know how long I'll be on SGS. The staff hasn't given me any idea of when

it might end. They usually don't. In my experience SGS status can last anywhere from 1 day to 3 months.

9. Right now, there are about 4 kids on SGS, out of a total of around 16 kids at MDH. There have been up to 6 kids over the last few weeks, but some of them were transferred to IDJJ or released. I have seen as many as 7 kids on SGS at one time. But I've heard that at times the entire facility has been on SGS.

10. Another way staff discipline is by putting kids on Behavioral Plan. While on Behavioral Plan, you can spend more time out of your cell, but you have to do your "plan" which includes talking to staff about what you did and writing "thinking reports." You can't do normal recreation activities until you finish your plan. You still end up isolated in your cell for 21-22 hours on Behavioral Plan. The only difference from SGS is just that you have some meetings and papers to complete, sometimes in your cell, and sometimes just outside of it.

11. I've been on Behavioral Plan four times during my recent detention at MDH. It's a pretty common punishment here. Behavioral Plan used to be called "shifts" until IDJJ audited MDH and told them to change it. This just meant solitary confinement for a certain number of staff shifts. Previously, you could have multiple shifts a day and spend almost all your time in your cell.

12. I spend so much time in my cell at MDH and it is the most boring thing ever. There is nothing to do but walk a few feet back and forth and stare at the wall. I've asked for books but still don't have any, and I can't listen to any music. I am forced to eat by myself in my cell. I really don't speak to anyone the entire day other than with staff during food drop-off and occasional checks. Sometimes I talk to other kids on my wing, even though we're technically not supposed to and we can get in trouble for it. I just really want to talk to someone while I'm in here because it's driving me crazy. I feel so isolated. Sitting in a cell all day by myself really messes with my

head. I sometimes cry in my cell and feel depressed. This place really makes me go crazy.

13. Even before I was put on SGS, I spent the vast majority of each day at MDH alone in my cell. I came out of my cell for recreation periods, meals, showers, and school for a total of about two and a half to three hours per day. The other hours were spent in my cell, just like during SGS.

14. During the last few meetings with my lawyers, the meetings were the first time I came out of my cell for the day, and I returned to my cell right after my legal visit. Some of the staff consider my legal visits with my lawyers as my recreation period.

15. The limited time I get out of my cell is for "free time" recreation. When you're not on SGS, you can choose your rec activities, like playing basketball or watching TV. When you're on SGS like me, the staff decide where you do your rec and sometimes what you do for rec.

16. I don't get real exercise. Most days the staff makes us do rec in the wing. I only get the choice to exercise during rec about twice a week, and even then it's just to play basketball by myself and it's for such a short time that I can't really exercise or move my body much at all.

17. You don't get in-person visits when you're on SGS. Typically, I get two personal telephone calls per week, each lasting 15 minutes, timed by the staff. While on SGS, I have to do my phone calls during my limited rec periods, which means if I take a call then that takes away from my few minutes of time to exercise or do anything else outside my room. This also means that if the person you're calling isn't available during that short time you can't talk to them. I have had a hard time reaching my grandmother because she's usually not available when they let me call her during rec. This has been hard on me and on her.

18. My cell is small, with concrete walls and a large fluorescent light above my bed that never turns off, making it very hard to sleep. I've never gotten a full night's sleep at MDH and

I'm constantly tired.

19. I don't really have any real mental healthcare at MDH. There's only one counselor who comes in from the outside visits our cells for brief 15-minute periods to ask us how we're doing, but these conversations aren't private, she just talks to me through my door. I need to speak to a psychiatrist in private because this environment is really affecting my well-being. All the other kids can hear our conversations with the counselor so I can't really say anything, and she's only here maybe 2-3 times per week.

20. I'd really like to talk to a mental health professional because I'm currently on suicide watch. I told staff that I was feeling suicidal, so they put me on suicide watch while I'm also on SGS. I've been on suicide watch for about three or four weeks straight now and I still feel suicidal and have suicidal thoughts. Just sitting in my cell all day, thinking about everything, it just brings me down even more. I don't think the facility takes suicide watch seriously. When you're on suicide watch and SGS, you stay in your cell basically all day. Staff check on you every 15 minutes but don't talk to you—they just make sure you're not harming yourself. I've asked to speak with someone from Bridgeway for additional mental health services because I heard they are the people who are supposed to talk to us about mental health, but MDH always tell me that Bridgeway declines to meet with us. The staff says they don't want to talk to us kids for some reason.

21. When kids are on SGS and suicide watch, you typically don't get books, your sheet is removed from your bed, and you get rubber utensils instead of plastic. Sometimes staff will put you in a turtle suit, which is an anti-suicide smock that is supposed to keep you from hurting yourself. I've had to wear the turtle suit before but not now, which is good because it's uncomfortable.

22. Since I've been on suicide watch and SGS restriction, I've only been able to talk to the counselor for 15-minute periods on my wing. Over the last few weeks, while I have been on SGS and suicide watch, the counselor visited me about once a week. She comes to my wing and stands outside my cell door to talk to me, which lasts less than 15 minutes. It wasn't a private session because the other kids on my wing were there and could listen in. After finishing with me, the counselor moved on to other kids on my wing, and I could hear those conversations too. Only the kids on SGS restriction have to do their counseling sessions this way.

23. Kids who aren't on SGS restrictions can visit the counselor privately in the nurse's office for much longer, sometimes up to 45 minutes. I used to do this before I was put on SGS.

24. I'm supposed to be a senior in high school, but I don't really go to school at MDH. While on SGS, I haven't been going to school at all. When I wasn't on SGS, I'd maybe do 45 minutes of school each day. I've never been to school in the classroom at MDH and I barely talk to the teacher. I have had to do my "work" with some other kids in the living dayroom area. Since my most recent detention and my last stay, I have not been in the classroom. The "work" that we do are just packets of worksheets that I've already done before. The teacher just recycles the same work. It's also like third-grade work and not grade appropriate.

25. I don't think I'm even getting credits for the work that I do, or at least, I don't know how many credits I have to graduate. I would like to graduate and get my GED but I have no way of knowing if I'm going to do that while at MDH.

26. I've been doing tutoring through IDJJ because I'm eligible for their compensatory education program even while I'm at MDH. It's the only real schoolwork I've been doing, and I actually feel like I'm learning something and I'm excited to do it. I am supposed to have tutoring every Monday. I've had two sessions so far, but have also had at least two sessions canceled

because the staff couldn't handle setting up the tutoring. When I do have my tutoring, my tutor and I focus on GED subjects because I want to get my GED.

27. When I was out in the community, I tried to go to school every day. I received okay grades, and I particularly enjoyed classes like business and entrepreneurship and science. In MDH, I feel like I'm falling behind in school.

28. I don't have access to adequate medical care at MDH. There's a nurse who occasionally visits the facility, she hasn't been helpful. I'm supposed to take two medications for mental health conditions I have, but I'm only receiving one medication right now. The staff haven't explained why I'm not receiving my other medication.

29. One time, I had a really bad headache. It felt like my head was splitting open, and the fluorescent light in my cell wasn't helping. I asked staff for medicine, but they said the nurse wouldn't be back until Monday, so I had to deal with the headache all weekend.

30. MDH doesn't feed kids enough. I'm always hungry after my meals at this facility, and I've asked staff for seconds but they don't give it to me. Staff also eat meals before us and eat what are supposed to be the kids' snacks.

31. While on SGS, the food I get is different from what the other kids get who are not on SGS. For example, one day the non-SGS kids got fried chicken wings, but I wasn't allowed to have them because the staff didn't trust me with the chicken bones. So, instead, I just had to eat a chicken patty, which wasn't as good. Another time, non-SGS kids got McDonald's, but I had to eat something else that was nasty and didn't taste good. Also, while on SGS, I don't have access to commissary (the "Mary Mart") so I can't buy snacks for myself when I'm hungry.

32. I do not believe there are enough staff at MDH to operate the facility. There are typically four or five staff on duty at a given time, with one remaining in the central "control

booth." There should be at least 8 staff per shift. Staff have said they don't have enough people to watch over us at MDH. That's why we end up spending a lot of time in our cells and don't get to go to rec.

33. The staff are rough with kids here. I saw one CO during my second or third detention at MDH slam a kid on the ground because he refused to go back to his cell.

34. Staff have also been rough with me. A few weeks ago, after the incident where the nurse wasn't giving me my medication, staff restrained me with handcuffs and ankle shackles. They had me on the ground, one staff member with his knee on my back to hold me down while they called the sheriff. I was restrained for what felt like 30 minutes before the sheriff arrived. The handcuffs and shackles were very tight, and it felt like they were cutting off my circulation. When the sheriff got there, he removed the restraints, but then staff put me on SGS. They took away my sheets, books, and shirt and left me in my cell. I got a new shirt the next day.

35. Last week a staff member restrained me by choking me, and punching my arm when I tried to grab on to a door, and ripped out one of my dreadlocks. He left me shackled in my room afterward. The staff also took my mattress and my belongings—they tore up my paperwork, including song lyrics I was working on, and important phone numbers I needed, right in front of me. That really bothered me to see my personal things torn up like that, those were things that were important to me. I don't know why they would do something like that other than just to mess with me and make me feel bad.

36. If there are behavioral incidents there are not enough staff to deal with them. I have seen staff call local police to come to the facility on multiple occasions.

37. Staff also strip search kids. During my second stay, staff pulled each youth out into the hallway and told them to strip completely naked. Some kids were stripped in the hallway, while

others were stripped within their cells. I was in my cell when the strip search happened. Three COs came into my cell and told me to strip. They did not explain what they were searching for or why I needed to be searched. I didn't want to do it, but it seemed like I had no choice. I took off my clothing in front of three male staff members, who then told me to bend over and cough while they looked up behind me.

38. This strip search was humiliating and traumatic, I felt violated afterward, and I still think about it.

39. MDH has really messed me up. I've got nobody to talk to, and the staff never listen. It's driving me crazy. I feel isolated, and it makes me feel different in the outside community after being in detention. I just want to stay in my room all day at home because I still feel like I'm in a cell. It's hard to adapt to the real world. It makes me feel crazy. I'm quiet and won't talk much. While I'm here at MDH, I feel depressed, angry, violated, and just helpless. There's nothing I can do, and I can't talk to anyone.

40. I have complained to staff so many times about the conditions at MDH and have written at least 20 grievances, but nothing ever changes.

41. MDH is much worse than my time at IDJJ or Focus House, mainly because of how much time we have to spend alone in our cells. At least at IDJJ, I have plenty of time out of my cell and can attend school and I can listen to music, read books, and do other rec activities.

42. The lawyers in this case have explained to me about this lawsuit and explained the class action process to me and I understand they are trying to bring a case as a class action. I want to help other kids who go to Mary Davis Home, so no one has to experience what I am going through here.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 7th day of June 2024.

Respectfully submitted,

J[redacted] H[redacted]

Exhibit 2

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS

J.B.H., by his next friend Debra Medlock, and A.M., by his next friend Rachael Puig, on behalf of themselves and all others similarly situated, Plaintiffs, v. KNOX COUNTY, CHIEF JUDGE RAYMOND A. CAVANAUGH of the Ninth Judicial Circuit Court, BRIDGET E. PLETZ, Director of Court Services of the Ninth Judicial Circuit Court, and WENDI L. STECK, Superintendent of the Mary Davis Home, Defendants.	)	Case No. 24-cv-04096-JES-JEH Hon. Judge James E. Shadid

DECLARATION OF A.M.

I, A[redacted] M[redacted], pursuant to 28 U.S.C. § 1746, declare as follows:

1. I have been detained at Mary Davis Home ("MDH" or "Mary Davis") since around March 10, 2024. I am 15 years old.

2. This is my second time being detained at MDH. The first time was for about a month in December 2023. I've also been held at a juvenile facility in Davenport, Iowa, and at the Illinois Department of Juvenile Justice.

3. Currently, I'm in the Lower East wing at MDH, but I've been on Lower West and Upper West wings before during my previous stay.

4. Since my second stay at MDH, I've mostly been on "Special Group Status" or "SGS." This means I stay in my cell for 23 hours a day, sometimes more. I am supposed to get 30 minutes of recreation time per shift (two shifts a day, so one hour total), but staff often cut it down

to just 15-25 minutes per shift.

5. When I'm on SGS I eat all my meals in my room by myself.

6. Since my latest detention, there have only been about 10 days in total where I haven't been on SGS. On all other days it's been 23 and 1.

7. SGS is really common at MDH. I've been put on SGS twice during my most recent stay. The first time happened just a few days after I arrived at MDH when a whole group of kids were put on SGS after a big fight between kids and staff. The second time, I was put on SGS for fighting with another kid, and that happened about a month ago. The other kids in my wing are on SGS—there are 3 of us on my wing and another one in another wing. The most kids I've seen on SGS at one time at MDH is 7.

8. When staff has put me on SGS they don't tell me when it will end, I just have to wait and guess. Staff didn't tell me how long my SGS would last either of the times I was put on SGS during this most recent stay at MDH. When staff put me on SGS a few weeks ago, they didn't tell me how long it would last, so I've just been waiting. Just this week they told me that if I wrote down three things on a piece of paper that I won't do, and if I comply I'll be taken off SGS. I have no idea if this will actually happen because they have broken promises before. It really bothers me and frustrates me when I have no idea when I'll get done being locked down, it feels like it will never end.

9. When I do get to come out of my cell for my rec time while on SGS, I mostly just stay in the wing. Occasionally, I get to play basketball in the gym or outside, but that is pretty rare. Most rec days just involve watching TV in the hallway between our cells, which is just a few short steps from our cells.

10. I don't get much time to exercise at the facility, and it's frustrating. Except for doing

push-ups in my cell when I can, there aren't many opportunities for physical activity. It's tough not being able to move around and stay active like I used to—in the community, I played football and basketball pretty regularly.

11. The other form of punishment that staff use is called a Behavioral Plan. That's when kids are allowed out of their cells, but only to do their "plan" during this time, which is usually filling out forms and talking to staff about why they got put on Behavioral Plan. Kids can't do regular rec until they've completed their plan. Since my latest stay at MDH, I haven't been placed on Behavioral Plan. Instead, staff just put me directly on SGS.

12. I'm supposed to be a freshman in high school, but I don't really go to school at MDH. Since I've been on SGS, which has been basically my whole time here, I haven't been attending school at all. I haven't been in a classroom. I haven't interacted with the one teacher at MDH at all during my most recent stay. I've barely even received any packets or assignments to work on outside of a classroom. I've only received schoolwork packets twice since I arrived at MDH. The packets are really easy, and sometimes they're repeated, so I've done the work before. I have to do the packets in the area between the cells. I rarely get feedback or a grade.

13. I don't really have anyone to talk to in this facility, and it would be helpful to speak to someone like a therapist. There's one counselor who comes by the facility about 2 times a week, but she barely spends any time with the SGS kids. When you're on SGS, she can only meet you in your wing. She stands outside your cell door and asks you questions like how you're doing and if you're feeling suicidal. But because these conversations take place in the wing, I don't feel like I can be really honest with her about how I'm doing with other kids listening. Plus, these conversations last only a few minutes.

14. I have to take medications to help me deal with conditions I've been diagnosed

with. Sometimes staff doesn't give me my medications, and it feels like they're doing it as punishment because they are upset with me. They will just say, "We can't give it to you tonight." This is frustrating because I need the medications to help keep me calm and feeling OK, especially when I'm locked in my cell. Being locked in a cell for 23 hours a day definitely makes my symptoms a lot worse and makes me feel more and more upset.

15. Not getting my medication is also frustrating because it makes it even harder to sleep, and I already don't get enough sleep in here. I struggle to sleep at night. I have a lot of night sweats and have traumatic flashbacks from my past experiences that keep me up and make my mind race. My medication helps me sleep. But sleeping at MDH is hard in general because the lights are always on, including the big light over my mattress. I typically only get about 3 hours of sleep at night.

16. I've never been on suicide watch while I was on SGS, but I've seen other kids on suicide watch. Everybody knows if you're on suicide watch because staff slaps a colored tag on your door, which means you're on suicide watch. There is a kid on SGS in my wing who is on suicide watch right now. Staff don't move kids out of their cells when they are on suicide watch, though—they stay 23 and 1. They don't get any special doctor visits or anything, they just stay in there locked up which seems wrong if they are really so messed up they might hurt themselves. But otherwise suicide watch is just solitary.

17. Staff can be violent and physically aggressive with the kids for no good reason. I've seen them throw kids around and slam them, and it's happened to me too. Just last week, the Assistant Superintendent came into my room and asked for my hygiene cup, which is the cup where you keep your toothbrush, soap, and other hygiene items. When I didn't give it to him right away, he got angry and slammed my head into the concrete wall in my cell. Another time, a

different staff member slammed me into the wall of the gym, and I ended up with a concussion that required me to go to the emergency room.

18. During my first stay here around December 2023, there was a facility-wide strip search. Staff said they were looking for a missing pen. During the search, they told all of us to come downstairs. They patted us down and used a wand like a body scanner. After that, they searched my cell and sent me to another empty cell. That's when they conducted a full strip search. It was two male staff doing my strip search. They forced me to strip completely naked. The strip search made me feel violated, and I really didn't want to do it. I didn't want the staff members to see me like that. They did this to every kid in the facility just to look for one pen.

19. Staff don't always give us enough food. Sometimes I'm still hungry after meals, and since I'm on SGS, I can't buy any extra food from commissary. I just have to deal with the hunger. Plus, kids who are not on SGS get better food. For example, the other day they got fried chicken, while SGS kids got a plain chicken sandwich.

20. I have complained to staff about how they treat kids by writing grievances, but I haven't heard back and they definitely don't do anything to try to fix the problems I complained about.

21. MDH is a bad facility. This facility is worse than any other I've been in because here, I'm in my cell for 23 hours a day. In other facilities, I could at least come out of my cell more. The staff are too rough with the kids here, and being confined all day really gets to me. It's like I'm trapped in my own thoughts, and the isolation just makes everything worse. I can feel my anger building up as I just sit in my cell all day, with no one to talk to or really anything to do. I know I have to keep my anger inside me because that's the only way I can get out of SGS, though. It's really hard because I get so agitated being locked in by myself. Staff keep looking for you to

get angry and then they use it as an excuse to keep you in your cell. It makes me feel trapped.

22. It feels like staff don't see us as kids or even as human beings because of the way they treat us.

23. The lawyers in this case have explained to me about this lawsuit and explained the class action process to me and I understand they are trying to bring a case as a class action. I want to make sure that other kids at Mary Davis Home don't have to go through what I'm experiencing.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 7th day of June 2024.

Respectfully submitted,

Exhibit 3

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS

J.B.H., by his next friend Debra Medlock, and A.M., by his next friend Rachael Puig, on behalf of themselves and all others similarly situated, Plaintiff, v. KNOX COUNTY, CHIEF JUDGE RAYMOND A. CAVANAUGH of the Ninth Judicial Circuit Court, BRIDGET E. PLETZ, Director of Court Services of the Ninth Judicial Circuit Court, and WENDI L. STECK, Superintendent of the Mary Davis Home, Defendants.	)	Case No. 24-cv-04096-JES-JEH Hon. Judge James E. Shadid

DECLARATION OF N.J.

I, N[redacted] J[redacted], pursuant to 28 U.S.C. § 1746, declare as follows:

1. I have been detained at Mary Davis Home ("MDH" or "Mary Davis") four times. The first time was when I was 15, for 4 months. My second and third times were in September 2022 (about 2 weeks) and November 2022 (about a month). My most recent and longest stay at MDH started around April 2023. I am 17 years old now. I turn 18 in August.

2. MDH has four wings: Upper West, Lower West, Upper East, and Lower East. I have mainly been in the Lower West wing during my most recent time at MDH, but I have also spent time in all the other wings during my different detentions at the facility.

3. My cell is very small. There is a hard cement slab with a thin mattress against the right side of the cell. Next to the cell door, there is a combined toilet and sink. All the cells I have been in have been set up in basically the same way.

4. There is a large bright light right above my bed that never turned off, even at night. It makes it almost impossible to sleep for a long time, especially because I already am in a bad state of mind from being locked in a room by myself so much, and because staff are always provoking me.

5. I do not have a pillow. I requested one from the staff more than once, but they have always denied my requests. Every kid at the facility usually gets one sheet and a thin blanket even though it's cold at night during a lot of the year.

6. I spend almost all my time in my cell at MDH. From when I wake up until I fell asleep, I am usually confined there. I am in my cell about 23 hours a day due to being on confinement for punishment, which is what staff calls "Special Group Status" or "SGS." Even when I was not on SGS, I still spent at least 20 hours a day in my cell.

7. Special Group Status is one of the ways MDH staff punishes kids at the facility. If you are on SGS, you basically cannot leave your cell at all, except for 7-minute showers, and sometimes for 30-minutes of recreation time in your wing (you cannot leave your wing, so you cannot use the basketball court or outdoor rec area) but that is only if staff feel like letting you out for rec, which is rare. So usually your rec time is just on your wing which is really the hallway between the cells. I eat all 3 meals in my cell. It is basically 23-1 in your cell.

8. When you get put on SGS you are basically on SGS until a staff member tells you otherwise. You don't really know when you are going to get out which makes it even worse. There's supposed to be a review of kids' SGS status every Wednesday where the Superintendent and staff get together and share their opinions about whether your SGS status should end. If they don't decide to let you out it's usually at least another week. It's usually the same staff who put you on SGS that decides whether to remove you from it, so if you have a staff member that doesn't

like you there's no real way out. This is what happened to me, staff straight up told me I am never getting off SGS as long as I'm at MDH.

9. During this most recent stay at MDH I have been placed on SGS about 4 times. The first time was for a month (April-May 2023), the second time for 4 months (September-December 2023), the third time for 2 weeks in late December 2023, and the fourth time started in March 2024 . This latest SGS was imposed after I argued with staff about their refusal to follow MDH's rules requiring staff to allow youth to serve 15-minute "time out" periods in a chair in the common areas of the facility instead of their rooms. One staff member told me she did not care about the rule and was going to force me to serve a time-out in my room. This wasn't fair, and I was tired of being in my room, so I refused to go. The staff restrained me, forced me into my room, and placed me on SGS. I'm still on SGS and don't expect to ever get off.

10. I cannot talk to anyone, not even kids in nearby cells. Staff moved the other kids on my wing to rooms further away from me so that I can't talk to them. Staff does short check-ins every 15 minutes, but they do not talk to us much. Sometimes I go days without speaking to anyone.

11. Being alone all the time and not talking to people messes with my head. Isolation really kills a person on the inside. I feel really bored and restless, and it is like time would move so slowly. Getting treated like this makes you feel cut off from the world, and cut off from people almost like you are not a person yourself. When you spend that much time by yourself cut off from other people you really feel inhuman. After a while solitary confinement makes you feel like you are not there, and like you are not valued by the world. It's wrong and it made me feel angry and sad all the time.

12. The worst thing about being in SGS as often as I am is that the staff just starts trying to provoke you. Staff is always pushing me and teasing me and trying to get me to act out and then punishing me when I get angry, like a vicious cycle. This all just makes me even more angry than I already am stuck alone in a concrete room all day. It feels like they are making a game of trying to get me in trouble and seeing how much I can take.

13. I try to pass the time by reading books, but sometimes the staff doesn't give me any, or they only give me ones I have already read a dozen times. It's frustrating and makes the isolation even worse.

14. The other form of confinement they use for punishment at MDH is called a Behavioral Hold, sometimes referred to as a Behavioral Plan. When I first arrived at MDH in 2022 at 15 years old, a Behavioral Hold meant being confined to your cell for 24 hours without any exceptions. It was even harsher than SGS. They made some changes to that punishment so you are supposed to do some particular things to complete your Behavioral Plan and sometimes the guards let you do those things, like paperwork and meetings, in the hallway in your wing. When that happens you are in your room more like 20 hours instead of 23. But even that doesn't always happen because it's all up to staff and sometimes there are not enough of them to let you out of your room, or they just don't feel like it.

15. When you are out of your cell on Behavioral Hold, you have to follow "your plan." This could mean counseling sessions, groups, or "thinking" worksheets where you have to write about what you did to get punished. But you need a staff member to start your plan and help you through it. If no staff member is available, you stay in your cell until somebody is available to get you started. The longer it takes to finish your plan the longer you are stuck in confinement.

16. You can get put on Behavioral Hold for really anything. I have seen the staff at MDH put kids on Behavioral Hold for swearing, talking back to staff, farting, or talking to their cell neighbor.

17. Behavioral Hold is so common at MDH that between Behavioral Hold and SGS it feels like I am pretty much always on solitary confinement. I have been put on a Behavioral Hold so many times that I have honestly lost count. The last time was for one day, for messing around and joking with another kid at the facility – not even getting violent or fighting. The staff has gotten to the point where they will punish me for even the smallest thing.

18. Behavioral Hold starts with 24 hours, but staff can add more time if they want. The longest I have been on Behavioral Hold was 4 days for cussing.

19. Once, I was put on Behavioral Hold for 2 days because I spoke to the IDJJ auditor during their inspection of MDH. I knew this was the reason because right after I spoke to the auditor, I was immediately put on Behavioral Hold, even though I had not done anything else.

20. Sometimes you will not even know if you are on Behavioral Hold. The staff will just come to your cell and slap a sticker near your door with the date and "BHP" without explaining why.

21. Multiple kids at MDH are usually on Behavioral Hold at any given time.

22. The facility used to have a place called the Harvest Wing that is a hallway with cells used for just segregation. Kids who were sent there would stay for weeks, sometimes months. Although I was never placed in the Harvest Wing myself, I witnessed other kids being sent there. Back in 2022, during a previous stay at the facility, I remember a 14-year-old girl being put in the Harvest Wing. I think she had serious and obvious mental health issues. She would scream constantly from the Harvest Wing and staff attempted to drown out her screams by running a fan,

but it didn't really work. It put all the other kids on edge to hear her screaming like that, it wasn't right.

23. Kids who are not on SGS or Behavioral Hold are supposed to get recreation but it does not always happen. Even when it does, it is only for 20 to 30 minutes per shift (there are two shifts during the day). Usually, it is indoor recreation, a lot of times just sitting around on our wing to watch TV. We don't go outside at all when we're on SGS. Even when I was not on SGS I rarely went outside for recreation, usually only when there are enough staff and they decide to do it.

24. I have never gone to school full-time while I've been at MDH. For the last few weeks I have not done any school work at all.

25. I do not have regular classes or face-to-face instruction with the teacher at MDH. Although there is a classroom at the facility, I have never done any schoolwork there.

26. The only schoolwork I have done has been worksheets that I do on my own in my living unit or sometimes in the shared living area in the middle of the facility. The worksheets are not graded, and I have not gotten much feedback from the teacher. None of these worksheets have been at my grade level (I am a senior in high school), especially the reading assignments, which are way too easy.

27. The facility is supposed to have this system called OWL which when it works is supposed to let me videoconference into the classroom, but the OWL system never worked. The staff at MDH only turn it on when IDJJ came to audit the facility.

28. There is only one teacher at MDH. If the teacher is absent, kids either don't go to school, or the COs give us makeup work, usually just reading the newspaper or doing other easy tasks.

29. I have a Behavior Intervention Plan, but nobody at MDH has followed it, or even talked to me about it. I have mentioned it to staff, but nobody listened.

30. In or around December 2023, the staff at MDH did a facility-wide strip search because there was a missing pen. On that day, the staff locked down the facility and went cell by cell to strip search the kids. When they got to my cell, there were two male COs in my cell to do the search. They made me take off all my clothes, including my boxers. The COs then told me I needed to lift my genitals so they can look and do jumping jacks. I refused and tried to cover myself up because I felt very uncomfortable. The COs then left me fully naked in the cell for 30 minutes until I complied. I felt like I had no other choice, so I eventually did the jumping jacks.

31. The COs made it clear that if I did not go along with the search, they were going to either use force or put me on Behavioral Hold.

32. There was another facility-wide strip search in or around February 2024 where the COs did the same thing.

33. Another time, I saw COs cut the clothes off another kid in my wing with a knife because he did not immediately agree to the strip search. They basically stripped him violently and strip searched him involuntarily where other kids could see. It was very difficult to watch.

34. Strip searches are a common thing at MDH. I have been strip searched more than 5 times during all my stays at the facility.

35. The COs are really rough with these kids at MDH. They restrain kids by throwing them to the ground, using riot shields, using chokeholds, and ganging up on kids. One time around July 2023, a CO came up from behind me, placed his knuckles on my temple, and his other arm around my neck, basically trying to chokehold me and knock me out.

36. The facility also does not have adequate medical care. I was really sick around the holidays last year. I was throwing up constantly, including throwing up blood, I had lost weight and couldn't keep any food down. I told many COs about this, and all they asked me to do was "show them the blood" that I was throwing up. Sometimes I couldn't show them the blood because I had flushed it already, but even when I did show them the blood they didn't do anything about it. It took staff 7 days to get me any medical attention, which included having to take me to the hospital.

37. In my last few months at MDH, I had really bad toothaches. I think I had cavities. I needed to see a dentist, but my appointment was canceled because of my behavior—at least that is what the superintendent told me.

38. While I was locked up, I had suicidal thoughts and was placed on suicide watch. As far as I could tell that just meant that my regular utensils I had to use to eat in my room were replaced with rubber utensils I couldn't use to cut myself.

39. While I was isolated I eventually got so angry and sad that I started cutting myself on the chest and arms. Many staff members knew about this but did nothing to help me – they just searched me and my room all the time to try and find what I was cutting myself with. The staff at MDH never provided me with the help I needed, and the mental health counselor they had only talked to me a few times and was not helpful.

40. From everything I have seen, and from talking to other kids through the cell walls and in the dayroom, the other kids at MDH have it bad too. I've heard lots of kids get put on SGS and Behavioral Hold. As far as I know kids do not go to school full-time.

41. I have complained dozens of times about the conditions at MDH, but no one from the facility has ever fixed the problems. If you complain about something, your complaint just

disappears and you never hear about it again, or worse, they might use it against you and put you on Behavioral Hold—that is what happened to me.

42. My time at MDH has been horrible. It has changed me. Being locked up by yourself all the time messes with your head and makes you go crazy and feel dehumanized. This place brings out the worst in everyone. They make you go crazy and then it's like they punish you for acting like that.

43. The lawyers in this case have explained to me about this lawsuit and explained the class action process to me and I understand they are trying to bring a case as a class action. I want to help other kids who go to Mary Davis Home, so no one has to experience what I went through there.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 22nd day of April 2024.

Respectfully submitted,

[redacted]

Exhibit 4

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS

J.B.H., by his next friend Debra Medlock, and A.M., by his next friend Rachael Puig, on behalf of themselves and all others similarly situated, Plaintiffs, v. KNOX COUNTY, CHIEF JUDGE RAYMOND A. CAVANAUGH of the Ninth Judicial Circuit Court, BRIDGET E. PLETZ, Director of Court Services of the Ninth Judicial Circuit Court, and WENDI L. STECK, Superintendent of the Mary Davis Home, Defendants.	)	Case No. 24-cv-04096-JES-JEH Hon. Judge James E. Shadid

DECLARATION OF M.P.

I, M[redacted] P[redacted], pursuant to 28 U.S.C. § 1746, declare as follows:

1. I have been detained at Mary Davis Home ("MDH" or "Mary Davis") since around April 2, 2023.

2. I am 15 years old. I was 14 years old when I first got here in 2023.

3. This is my first time being detained at MDH, and at any juvenile detention center.

4. There are four wings or living areas at MDH. I have been in the Lower West wing for most of my time at MDH, but I have spent time in other wings, including Upper West and Upper East. They are all set up basically the same.

5. My cell is very small. There is a cement slab with a thin mattress for sleeping, a small shelf, and a cubby where you can keep a few personal items. Next to the door, there is a combined toilet and sink.

6. Above my bed, there is a bright light that never turns off. It wakes me up most nights and makes it very hard to sleep.

7. My cell is not a comfortable place and it is not a place where I like spending time at all, but I spend almost all my time there. I spend most of my time in my cell at MDH. On average I would say I spend about 19 hours a day in my cell when I am not being punished or on any restricted status. If I am being punished then it is worse.

8. Punishment at MDH can be pretty severe. One method staff use is the "Behavioral Plan." When you're on Behavioral Plan kids can only come out of their cells for a few hours a day to work on their Behavioral Plan activities like counseling, group activities, or working on a "thinking report," where you write about your feelings and what got you in trouble. You have to complete these activities in your living unit, usually in the hallway between the cells either by yourself or with any other kids on Behavior Plans. You still don't get any recreation time. Kids on Behavior Plans are in their cells around twenty to twenty-two hours per day.

9. You can get put on Behavioral Plan for really anything. I've seen kids get punished for swearing, talking back to staff, talking to their cell neighbor, acting "aggressive" or insulting someone. Behavioral Plan can last anywhere from a day to a week.

10. I have been put on Behavioral Plan as punishment while at MDH at least 20 times. Just last week, I was put on it for 3 days for swearing and talking back.

11. The other kind of punishment you can get is "Special Group Status" or "SGS." This means you can't leave your wing at all, except sometimes for 30 minutes of recreation each shift (there are 2 shifts during the day). SGS is worse than Behavioral Plan because you can barely leave your cell at all—you're just isolated. It's basically 23 and 1. I've never been put on SGS myself, but several other kids at MDH have, and there are usually multiple kids on SGS at any given time.

I've seen kids placed on SGS for up to two months. Staff treat these kids bad – they act like they are different from the other kids and like they are afraid of them.

12. When I first came to the facility saw staff put kids in isolation in a separate wing of MDH called the "Harvest Wing." This was also called "seg" for "segregation unit." I saw a kid around my first of the facility get put into a headlock or submission hold and dragged into the Harvest Wing. I'm not sure what happened to him after that. MDH staff stopped using that wing around June of last year. I heard some staff say they did this to get around a rule against using segregation units. But all they did was move segregation units into the regular wings.

13. Even though I haven't been placed on SGS, I still feel pretty isolated at MDH. I don't get to talk to anybody when I'm in my cell, and I can't even talk through the doors to kids in cells next to me. If I do that, I get in trouble. The staff do "checks," where they walk around the cells to monitor the area, but these only last a few minutes, and the staff doesn't talk to us much.

14. I've been at Mary Davis Home for so long that I've gotten used to being by myself all the time, but when I first got here, the loneliness and isolation really got to me. I get restless, so I try to pass the time in my cell by reading books or playing card games. Being locked up by yourself really does things to your mind. You find yourself getting angrier and angrier the longer you are stuck in a room alone. After that you start to just feel hopeless. It is just too much time to have to pass, it hurts you mentally.

15. I've hardly been outside since I got here. The last time was to watch the solar eclipse for a few minutes, but I can't remember the time I was outside before that.

16. I have never done anything at MDH that you could describe as "school." I only go to school for about 2 hours a day. It's definitely not full-time, and I rarely have lessons in the classroom. Instead, I do my schoolwork in the living area at the middle of the facility with some

other kids. The teacher at MDH doesn't really teach me, and I hardly get any feedback on my work. My schoolwork is also easy and at a sixth-grade level at most, even though I am a freshman in high school.

17. MDH used to use a system called OWL to let me videoconference into the classroom, but they don't use OWL anymore. Even when it did work, MDH only used it a handful of times.

18. In or around September 2023, MDH did a strip search to all the kids in the facility because there was supposedly a missing pen. Staff at MDH pulled each living unit into the gym, then forced kids one by one into an empty cell for a strip search.

19. When they pushed me into the cell the guards doing the search made me take off all my clothes, including my boxers. Then they made me lift my genitals and do jumping jacks. They also made me squat and cough. I really didn't want to strip, but I knew I had to because the COs were going to force me to do it anyway so I didn't really have any choice.

20. I was strip searched another time in December 2023, again because of a missing pen. They brought me into an empty cell in Lower West, and I backed up against the wall and begged them not to strip search me, and told them I did not agree to be stripped. The CO then threw me down onto the cement slab bed on my stomach and pulled my legs up behind my back. This put me in a twisted position and it really hurt. While that CO was restraining me, another CO started cutting my clothes and boxers off with a knife. There were at least 4 COs doing the strip search on me. and the COs left me naked in this empty cell until another CO finally gave me boxers. The whole search was extremely humiliating, and being left to sit naked by myself made it even worse.

21. I've been strip searched at least 5 other times but those times the COs let me keep my boxers on.

22. The COs are often aggressive and rough with kids at MDH. They restrain kids by throwing them to the ground, using riot shields in cells, grabbing and tackling kids, and using headlocks.

23. The other kids have it bad here too, and a lot of kids have it worse than me. Kids are getting put on Behavioral Plan or SGS very often, with multiple kids in solitary confinement at any given time. I don't know of any kids going to school full-time.

24. I have complained hundreds of times about the conditions at MDH and have written grievances, but nothing ever changes.

25. I've been through a lot at MDH, and I'm ready to leave and get out. It's tough dealing with the isolation and conditions here, but I try not to let it get to me. MDH really needs to change and be better, especially for the kids that are staying here. Being locked up at MDH has affected my mental health in a negative way.

26. The lawyers in this case have explained to me about this lawsuit and explained the class action process to me and I understand they are trying to bring a case as a class action. I want to help other kids who go to Mary Davis Home, so no one has to experience what I am going through here.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 22nd day of April 2024.

Respectfully submitted,

[redacted]

Exhibit 5

2022

2022 Inspection Report

KNOX COUNTY

JOHN ALBRIGHT

Executive Summary

The Department of Juvenile Justice conducted an annual inspection of Mary Davis Home in Knox County on February 23, 2022, pursuant to 730 ILCS 5/3-15-2(b). The Department observed several areas on non-compliance during this review, many of which warrant immediate attention. The sections and specific requirements of the 20 Ill. Adm. Code 2602 County Juvenile Detention Standards ("County Detention Standards") noted as non-compliant are listed in the table below, while specific observations are noted in the following sections of this report. Each section of the report also includes policy and practice recommendations to either gain compliance or move towards best practice. Those recommendations are combined in a second table at the end of the report.

Areas of Non-Compliance

Section	Requirement
2602.100 Clothing, Personal Hygiene, Grooming	Youth shall be permitted to shave as often as desired.
2602.110 Food Services	Meals shall be served and conducted in a group setting except when prohibited by security or medical needs. Three complete and balanced meals shall be served to each youth for each 24 hours of detention.
2602.170 Discipline	Youth shall not be deprived of the following basic rights as part of a disciplinary response: mattress, pillow, blanket, sheets; meals including evening snack; daily exercise; education. Room confinement may be used only as a temporary response to behavior that threatens the safety of the youth or others. Room confinement shall not be used for a fixed period of time, but only until the youth is calm enough to rejoin programming without being a risk to the safety of others. Supervisory staff shall be notified immediately when room confinement is used. At no time should room confinement exceed 4 hours without administrators and/or mental health staff developing an individualized plan to address the behavior.
2602.230 Education	Teacher student ratios are at least 1:12 for general education and 1:8 for students with Individualized Education Programs (IEPs). Qualified special education staff are assigned to youth with special education status and special education testing is available for youth in custody. There shall be a minimum of five hours of instruction per day.
2602.30 Personnel	A shift supervisor must be scheduled and available at all times and on duty during all waking hours and immediately available if not on duty during sleeping hours.
2602.50 Admissions Procedures	Youth shall be issued clean bedding . . . bedding shall consist of sheets . . . and a pillow. Following admission, a strip search may be administered only when there is an individualized, reasonable suspicion. Within 72 hours after the youth's arrival at the facility and periodically throughout a youth's confinement, the agency shall obtain and use information about

	each youth's personal history and behavior to reduce the risk of sexual abuse by or upon a resident. Assessments shall be conducted using an objective screening instrument.
2602.80 Medical and Health Care	A medical doctor shall be available to attend the medical needs of youth. General medical physician services shall be provided in accordance with one or more of the following procedures: on salary, in accordance with locally established personnel pay plan; a contract with local physician or clinic for full-time coverage at specific hours and for emergencies, a contract with a local physician to conduct sick call, to be on call for emergencies and to examine newly admitted youth; arrangements with a nearby hospital to provide all needed medical services; and services rendered, without cost, by another agency or department or with costs prorated. Access to psychiatric and/or psychological services shall be provided in individual cases as needed. Nonmedical detention staff may issue any form of over-the-counter medication, providing the facility physician gives prior written approval to the facility for the issue.
2602.90 Mental Health Services	All facilities shall employ or contract with qualified mental health professionals to address the needs of youth identified in the mental health screening, as well as needs that arise during the period of confinement. Services shall meet or exceed the community level of care.

Methodology

- Interviews Conducted
  - Superintendent Steck
  - Director Pletz
  - Assistant Superintendent Bonis
  - Stacy Brown (Vice-President of Bridgeway)
  - 12 youth
  - 2 supervisors
  - 6 counselors

- Documents Reviewed
  - Youth Grievance Samples
  - Youth Grievance Procedure
  - CPR and First Aid Training Documentation
  - Fire/Emergency Logs
  - 2020 Fire Inspection Report
  - 2021 Health Department Inspection Documentation
  - Menu Samples
  - Nursing and Educational Staff Certificates
  - Officer Safety Training Curriculum
  - Youth Orientation Manual
  - Facility Program Schedule
  - Use of Force Continuum

- 15-minute Security Check Logs
- Employee Training Logs and Background Checks
- Samples of Resident Files
- Medical History and Physical Form
- Detention Level Program (DLP) Sheets
- Supervisor Schedule
- Policy and Procedure Manual (Draft)

Overview

Mary Davis Home is a 39-bed facility in Galesburg, Illinois. The primary programming space is a large common area that is centrally located between the four primary living units (referred to as Upper East, Lower East, Upper West, and Lower West). There is an additional living unit called the "Harvest Wing" in a corridor off the main programming area that has three additional rooms, one of which has a camera. The facility has a gym space just off the primary programming space with a large window separating the two areas. A single classroom is off the main area as well. The classroom is quite large and was decorated in a manner consistent with a community school. The facility has an extensive library with several books available for youth. Facility leadership has made the development of the facility library a priority over recent years.

The on-site portion of the review took place on Wednesday, February 23, 2022. At the time of the audit, the facility had 17 residents (10 males and seven females) and employed a total of 27 employees (including one cook who has been out on leave for two months and five third shift staff). Sixteen staff are designated as counselors and manage the day-to-day work with youth. The facility is budgeted for four supervisory positions, although only three are currently filled.

At the time of the review, there were not any youth on any type of COVID quarantine status. Facility administrators reported that while COVID-19 has certainly been a challenge over the past two years, the facility has been able to maintain some of regular practices with some intermittent interruptions. With limited exceptions during COVID-19 outbreaks, the facility has continued offering in-person visitation two nights a week. The visitation area is sizable and has some artwork, including a mural that was recently completed by a local community college. It is commendable that the facility has continued offering in-person visitation and has a welcoming space to host. The facility also has video conferencing capability and has utilized it for court and professional visits. Video conferencing has not yet been offered for family visitation, but administrators reported plans to use video conferencing for family visits in coming months.

Admission Policy and Procedures

Mary Davis Home offers 24-hour coverage for admissions. Youth property is collected, inventoried, and laundered according to standards. During the facility walkthrough, auditors observed the property room in which youth personal clothing was organized into bins by youth. Inventory receipts were present in the bins with clothing, as well as youth files.

The facility conducts strip searches of all youth upon intake. County Detention Standards permit strip searches of youth upon admission only when there is an individualized, reasonable suspicion of weapons, contraband, or body pests.

An orientation is conducted by a counselor during intake. The facility has a Youth Orientation Manual that includes a broad overview of programming and rules. Some youth indicated a lack of clear expectations after the initial orientation and learning more from their peers in the days following admission. There are opportunities to enhance the youth orientation process to make it less transactional and more robust.

Medical screenings are conducted by the facility nurse, who consults with parents over medical history and medications. The nurse also inspects medications that youth bring into the facility. They are not reviewed by a physician.

PREA requirements include an assessment to determine risk for victimization within 72 hours of each youth's admission and periodically throughout a youth's confinement. The facility has a draft form to use for such assessment, but the form has not yet been approved and implemented. These screenings are not yet taking place. The facility has not undergone an official PREA audit. It would be beneficial to hire a PREA Officer to ensure there is an internal mechanism for monitoring facility compliance with PREA standards.

Areas of Non-Compliance and Recommendations

- 2602.50 Admissions Procedures states: "Following admission, a strip search may be administered only when there is an individualized, reasonable suspicion."
    - Recommendation:
        - Eliminate the use of strip searches as a standard process during intake.
- 2602.50 Admissions Procedures states: "Within 72 hours after the youth's arrival at the facility and periodically throughout a youth's confinement, the agency shall obtain and use information about each youth's personal history and behavior to reduce the risk of sexual abuse by or upon a resident. Assessments shall be conducted using an objective screening instrument."
    - Recommendation:
        - Implement the PREA Risk for Victimization Assessment for youth within 72 hours of admission and periodically throughout a youth's confinement.
        - Hire a PREA Officer to supervise facility compliance with PREA standards.

Personnel, Staffing and Supervision

At the time of the facility walk-through, most youth at the facility were confined in their rooms. Several staff were gathered in the common area of the facility for training. Staff and administrators reported that training is conducted every Wednesday; during training, youth are largely confined in their rooms. There was one youth in a classroom working individually with the teacher, but the remaining youth were confined in their rooms.

Administrators reported difficulty in filling positions over the past year. The facility is budgeted for four shift supervisors. One supervisor recently resigned, leaving only three to cover seven days of waking hours. Youth and staff indicated there are shifts during waking hours in which a supervisor is not present at the facility. Administrators attempt to cover these, but both staff and youth reported there have been shifts in which no supervisor is present. In these cases, the most senior staff present plays the role of a supervisor. Staff, youth, and administrators indicated there are times when counselor shortages lead to youth confinement in their rooms. County Detention Standards require that a shift supervisor be scheduled and available at all times and on duty during all youth waking hours. It is clear that the facility will need more budgeted supervisory staff in order to meet this standard, as covering seven days of youth waking hours by only four employees is not sufficient, especially when taking vacations and sick time into account.

In the meantime, there are opportunities to implement more efficient scheduling to mitigate supervisor and staff shortages. On the day of the inspection, there were several supervisors and line staff present. Administrators and staff shared that all supervisors are scheduled on Wednesdays to conduct training for line staff and have a weekly meeting. In contrast, only one supervisor is scheduled for the entire day on Sundays from 9am-5pm. This scheduling prevents compliance with the standard that a supervisor be present for waking hours and as noted above, results in youth room confinement. Staff schedules should be structured in a way that maximizes coverage across the entire workweek. Given the challenges the facility is currently facing with consistent supervisor and line staff coverage, and the youth confinement sometimes associated with it, staffing resources should be scheduled to reduce the frequency of such occurrences.

Areas of Non-Compliance and Recommendations

- 2602.30 Personnel states: “A shift supervisor must be scheduled and available at all times and on duty during all waking hours and immediately available if not on duty during sleeping hours.”
    - Recommendations:
        - Budget for more supervisory staff to ensure adequate coverage is maintained.
        - Ensure a supervisor is present for all shifts during youth waking hours.
        - Alter supervisor schedules to maximize coverage throughout the week.
        - Alter counselor schedules to maximize coverage throughout the week.

Detention Programs, Youth Discipline, and Confinement

The facility utilizes a point grading system to track youth behavior. Youth are graded on an A through F scale at the end of each shift. Grades are averaged daily and shared with youth at the start of the following day. The averaged grade is associated with certain privileges, such as later bedtime, candy bars, and extra visits. Youth on the highest level are permitted to stay up until midnight one night per week to watch movies.

Counselors facilitate daily Life Skills Groups. The content of the groups is largely determined by the staff facilitating the group, although some of the groups are designated as Social Skills Groups and use the Boys Town Social Skills Training Curriculum. One counselor described facilitating groups on job

interviews and other types of skills. Counselors described working to engage and develop relationships with youth during general recreation time as well. During the walkthrough, auditors observed counselors interacting with residents by playing cards with them and sitting with them during mealtimes.

While there are some strengths in the life skills programming and staff interactions with youth observed, the utilization of confinement as a response to negative behavior at the facility is a significant concern and must be addressed urgently. The facility utilizes a consequence called "shifts" to address negative behavior. When a youth earns a "shift" the youth is primarily confined to their room for the entirety of a shift (i.e., eight hours). The Youth Orientation Manual describes behaviors that earn between one to four "shifts," meaning youth are confined for eight to 32 hours for a single infraction. The Youth Orientation Manual also indicates the following:

> *"If you earn 1-2 shifts as a consequence you may be allowed to go to school; this will be based on your actions, how you reacted to being given the consequences, and whether there is a concern you will disrupt the class. You may be placed in a study carrel if it's available…. If you've earned 3-4 shifts you will not go to school. If possible, you will be given materials in your room to review so you don't fall behind and are prepared when you return to class."*

Both youth and staff interviews were consistent with the language in the Youth Orientation Manual regarding "shifts," namely that they equate to youth confinement.

The facility also utilizes "Administrative Plans" for behavior that, per the Youth Orientation Manual, "goes beyond shifts." Per the Youth Orientation Manual:

> *When on an Administrative Plan, you will have your movement restricted . . . This can be lifted once you earn a B for four weeks in a row. However, after two weeks of good behavior you can request the restriction be lifted early.*

Both youth and staff reported youth are, at times, placed directly onto "shift" or "Administrative Plan" confinement upon intake based on behavior from a previous stay.

Some youth on an Administrative Plan are housed in the "Harvest Wing." The "Harvest Wing" is located just off the main programming area through a door with a sign on it that reads "Segregation." Youth who were interviewed referred to this area as "seg." At the time of the inspection, two youth (a 15-year-old and a 12-year-old) were housed in the Harvest Wing. Both youths had a mattress, one blanket, and a book in their rooms. The youths did not have pillows and one stated the mattress was uncomfortable for his head because the mattress was torn and abrasive. The torn mattress was observed by the auditor. The youth reported he had been in segregation for about two months. Administrators estimated he had been there for approximately six weeks but could not confirm the exact amount of time. Administrators stated they try to get these youth out individually with staff each day for recreation, but at times it is inconsistent. Multiple youth also reported that recreation for youth in segregation was inconsistent. One of the youths in segregation stated he had been out for recreation the previous day for

approximately one hour but could not remember the time he was out prior. The other youth had trouble communicating when she was last out of her room and stated "I don't know" when she was asked how long she is out of her room when she does receive recreation.

Multiple youth reported that youth in segregation frequently have their water turned off for extended periods of time. A supervisor acknowledged that water may be turned off for the overnight shift so they don't have deal with youth flooding their rooms but will turn it on if a youth requests a drink of water or needs to flush a toilet. The auditor asked both youths if their water was on during their interviews. Both youths replied, "I don't know" and tried the faucets at prompting from the auditor. The water to both rooms was on, but the youth were surprised that it was and one stated "they must have forgotten to turn it off." The practice of turning water off as a preventative measure should cease immediately.

Youth, staff, and administrators reported that youth in segregation do not go to school, nor are they brought educational packets to work on independently. Administrators acknowledged that the youth who had been in segregation for six to eight weeks had not received any educational services during that time.

The practices Mary Davis Home employs regarding youth confinement are in significant violation of several County Detention Standards. These standards stipulate the following:

- Room confinement shall not be used for a fixed period of time, but only until a youth is calm enough to rejoining programming without being a risk to the safety of others.
- Supervisory staff shall be notified immediately when room confinement is used.
- At no time shall confinement exceed four hours without administrators and/or mental health staff developing an individualized plan to address the behavior.
- A full written report shall be made whenever room confinement is used.
- There shall be a minimum of five hours of educational instruction each day.

The facility utilizes a physical intervention technique called the SafeClinch Training System. The Use of Force Continuum highlights a process of staff presence, verbal de-escalation, and physical intervention using only the amount of force necessary to control a situation. The facility reported minimal use of mechanical restraints during physical interventions. The facility utilized pressure point control until July 2021, when the new County Detention standards were released. The Officer Safety Training curriculum provided states:

> *"At this point, this training is in addition to the other Officer Safety Training. None of the new techniques are considered "pain compliance" (which is what we currently use). Depending on requirements established by the Department of Corrections and AOIC, pain compliance may be forbidden or outlawed. Therefore, we are training techniques that are considered therapeutic holds."*

Training materials and policy should be drafted to explicitly state the use of pain compliance and pressure point control are prohibited.

Areas of Non-Compliance and Recommendations

- 2602.50 Admissions Procedures states: "Youth shall be issued clean bedding . . . bedding shall consist of sheets . . . and a pillow."
- 2602.100 Clothing, Personal Hygiene, Grooming states: ". . . youth shall be permitted to shave as often as desired."
    - Recommendations:
        - Provide all youth with sheets and pillows.
- 2602.170 Discipline states: "Youth shall not be deprived of the following basic rights as part of a disciplinary response: mattress, pillow, blanket, sheets; meals including evening snacks; daily exercise; education. Room confinement may be used only as a temporary response to behavior that threatens the safety of the youth and others. Room confinement shall not be used for a fixed period of time, but only until the youth is calm enough to rejoin programming without being a risk to the safety of others. Supervisory staff shall be notified immediately when room confinement is used. At no time should room confinement exceed 4 hours without administrators and/or mental health staff developing an individualized plan to address the behavior."
    - Recommendations:
        - Eliminate the use of "shifts" as a behavioral consequence and replace them with a short-term timeout process that releases youth as soon as they demonstrate they are calm and able to return to programming.
        - Eliminate the current practices associated with Administrative Plans and the Harvest Wing.
        - Ensure youth have adequate bedding and materials in their rooms.
        - Implement policy that prohibits the use of confinement longer than 4 hours without administrator approval and development of an individualized plan.
        - Enhance the documentation of youth confinement time to include:
            - Written reports that indicate the reason for confinement.
            - The start and end times of the confinement.
            - Attempts to de-escalate the youth and return them to regular programming.
        - Immediately end any practice of turning off water as a preventative measure and implement a policy that prohibits this practice.
        - Revise training materials and policy to explicitly prohibit the use of pain compliance and pressure point control.
- 2602.230 Education states: "There shall be a minimum of five hours of instruction per day."
    - Recommendation:
        - Deliver at least five hours of educational services to all youth each day, including those on special program statuses.

Medical and Health Care

There is one nurse that works at the facility five days per week for four hours each day. The facility has a sick call process by which a youth can request to be added to the sick call list, which is maintained in the control room to be given to the nurse upon her arrival. The facility does not have a medical physician on staff, nor is there an existing contract for a medical physician to provide services.

Areas of Non-Compliance and Recommendations

- 2602.80 Medical and Health Care states: "A medical doctor shall be available to attend the medical needs of youth. General medical physician services shall be provided in accordance with one or more of the following procedures: on salary, in accordance with locally established personnel pay plan; a contract with local physician or clinic for full-time coverage at specific hours and for emergencies; a contract with a local physician to conduct sick call, to be on call for emergencies and to examine newly admitted youth; arrangements with a nearby hospital to provide all needed medical services; and services rendered, without cost, by another agency or department or with costs prorated. Access to psychiatric and/or psychological services shall be provided in individual cases as needed. Nonmedical detention staff may issue any form of over-the-counter medication, providing the facility physician gives prior written approval to the facility for the issue.
    - Recommendations:
        - Hire or contract with a medical doctor.
            - Have a facility medical physician provide written approval to the facility before nonmedical staff can issue over-the-counter medication.
        - Hire or contract with an entity to provide psychiatric and/or psychological services.

Mental Health Services

Upon intake, all youth are administered a Massachusetts Youth Screening Instrument (MAYSI) by administrative staff. Scores on the MAYSI play a role in determining if youth are checked at a frequency of 10 or 15 minutes.

The facility does not employ any mental health staff. Mental health services are provided by a local community organization called Bridgeway, which is the area's Screening, Assessment, and Support Services (SASS) provider funded by the Illinois Department of Human Services. The facility does not have any formal contract or agreement with Bridgeway. The facility will call Bridgeway when youth are presenting with suicidal gestures or ideation. In these cases, a SASS worker reports to the facility to conduct an assessment and make recommendations for placing a youth on close watch or pursuing hospitalization. While Bridgeway can provide ongoing individual services, this is a rare occurrence. The Bridgeway Vice-President reported that she did not think there were any youth at the facility receiving recurring services. Outside of the MAYSI, there is not any form of routine mental health assessment administered to youth by a mental health professional during intake.

It is clear that the volume of mental health services available to youth at Mary Davis Home is insufficient to meet minimum standards, much less best practice. County Detention Standards require that facilities employ or contract with qualified mental health professionals to address the needs of youth identified in

the mental health screenings as well as needs that arise during the period of confinement. These services must meet or exceed the community level of care. Community Detention Standards also require that youth with significant mental health needs be assessed and have a service plan developed.

Areas of Non-Compliance and Recommendations

- 2602.90 Mental Health Services states: "All facilities shall employ or contract with qualified mental health professionals to address the needs of youth identified in the mental health screening, as well as needs that arise during the period of confinement. Services shall meet or exceed the community level of care."
    - Recommendations
        - Employ or contract with qualified mental health professionals to provide mental health services to youth at the facility.
            - Provide a mental health assessment for all youth.
            - Develop and implement service plans for all youth with mental health needs.

Clothing, Personal Hygiene, Grooming

The facility issues clothing to youth. Clothing and undergarments are scheduled to be laundered every day, a task that is managed by the overnight shift. The overnight shift is also responsible for discarding any clothing items that are damaged or stained.

The quality and cleanliness of clothing was a consistent complaint from residents that were interviewed. Youth shared they have received shirts with holes and stained undergarments. While not directly observed by auditors, the feedback was consistent. Female youth reported the quality and quantity of feminine hygiene products was poor and asked for additional options to be provided to them. Furthermore, some youth also indicate they were cold at times. The facility has a rule included in their Youth Orientation Manual that youth may only receive a shirt or a sweatshirt, but not both. This could easily be remedied by eliminating that rule and allowing youth the option of what to wear. Youth are permitted to shave, but per youth report and documentation, permission is only given one to three times per week.

Areas of Non-Compliance and Recommendations

- 2602.100 Clothing, Personal Hygiene, Grooming states: ". . . youth shall be permitted to shave as often as desired."
    - Recommendations:
        - Purchase new sets of clothing and discard any clothing that is damaged or stained.
        - Provide youth with the feminine hygiene products that are requested.
        - Provide all youth with shirts and sweatshirts.
        - Permit youth to shave as often as desired.

Sanitation

The general appearance of the facility was clean during the inspection. The facility has a cleaning schedule that meets the requirements of the County Detention Standards, including stipulation that youth rooms be swept and mopped, and bathrooms be cleaned each day. Youth reports differed from established policy, however, and several youths indicated they do not get a chance to clean their rooms consistently.

Recommendations:

- Implement a tracking and monitoring process to ensure the cleaning of youth rooms matches the established schedule.

Youth Grievances

Mary Davis Home has an established process for handling youth grievances. Youth grievances are assigned to supervisors initially to address and then to either the Superintendent or Assistant Superintendent. Grievances have traditionally been stored in resident files after resolution. The Superintendent began maintaining a log in January 2022 after the release of the new County Detention Standards in this area. The grievances reviewed by the audit team appeared to have been addressed within required timeframes.

Youth grievance forms are kept in the control room, so youth must ask a staff member for a form. The facility does not have any grievance boxes available to youth in common areas.

Recommendations:

- Make grievance forms available to youth without having to obtain one from a staff member.
- Place youth grievance boxes in youth living units and common areas.

Food Services

Mary Davis Home has a kitchen on-site and employs one full-time cook. The cook has been on leave for approximately two months, so food preparation is managed by facility staff, including the Superintendent who has stepped in on weekends. The facility offers three meals per day and a snack to youth on all days except Sundays. On Sundays, there are two meals, the first being a large brunch in the later morning hours. The facility maintains a record of menus and any alterations. A list of youth with special diets was posted in the kitchen. The facility had protein options present for youth on vegetarian diets, however there were complaints by some youth that these options have not been present throughout their stay. The facility does utilize one resident as a youth worker in the kitchen to assist with clean-up. The youth reported he enjoyed working in dietary.

Most youth receive their meals as a group at tables outside the kitchen. The facility does make frequent use of a consequence called “Dining Area Restriction.” Youth who receive this restriction are not permitted to eat in the dining area for a period of time and eat their meals in their rooms. This restriction can last quite a while, as the Youth Orientation Manual states the length of the restriction “*will be determined by your behavior, and you can request a review after the first two weeks is up.”* There were also some complaints from youth stating the food delivered while on a Dining Area

Restriction is different or less in amount than the meals provided in the dietary. Administrators indicated food should be the same, with the only change being the type of tray it is delivered on and some circumstances in which youth may be given a meal such as peanut butter and jelly in place of the primary meal if there is a safety concern over youth access to a utensil. The frequency of this is difficult to determine, however, practice should be to always provide youth the same meals in the same amount regardless of behavior status unless directed by medical staff.

Areas of Non-Compliance and Recommendations

- 2602.110 Food Services states, "Meals shall be served and conducted in a group setting except when prohibited by security or medical needs. Three complete and balanced meals shall be served to each youth for each 24 hours of detention."
    - Recommendations:
        - Implement a policy that specifically states all youth are to be delivered the same meal regardless of behavior status unless directed by medical personnel.
        - Limit the use of Dining Area Restrictions to instances where security or medical needs prohibit the serving and conducting of meals in a group setting.
        - Serve three meals on Sundays.

Education

The facility has one full-time teacher on-site from the Galesburg school district. Upon a youth's admission, the facility Assistant Superintendent reaches out to a youth's home school to obtain educational records and communicate to ensure youth get credit for educational services provided at the facility. The classroom itself is well-equipped and a welcoming space. Youth at the facility were very complimentary of the teacher, stating he is engaging and enjoyable to learn from. During the walkthrough, there was one youth in the classroom and the teacher was conducting a lesson on the stock market.

The program schedule provided shows four hours of in-person education each day. On Wednesdays, as was observed by auditors while on-site, youth engage in a study hall while staff training is taking place.

The County Detention Standards stipulate that the teacher-student ratio for general education needs to be 1:12 and 1:8 for special education students. Given the youth population at the facility – 17 on the date of the review and a reported average of approximately 20 youth - the facility does not meet the required ratios. Furthermore, County Detention Standards require five hours of education each day. As noted previously, some youth who have received "shifts" or are on a segregation status do not receive educational services. Facility administration reports they typically average one to two special education youth at any given time and the current facility educator is not a licensed special education teacher.

Areas of Non-Compliance and Recommendations

- 2602.230 Education states: "Teacher student ratios are at least 1:12 for general education and 1:8 for students with Individualized Education Programs (IEPs). Qualified special education staff are assigned to youth with special education status and special education testing is available for youth in custody. There shall be a minimum of five hours of instruction per day."

- Recommendations:
  - Hire a sufficient number of teachers, including special education teachers, to ensure the required ratios for general and special education are met.
  - Identify a process to have a substitute teacher in the event of a teacher absence.
  - Adjust the daily schedule to provide 5 hours of education to all youth each day.

Additional Observations

The facility offers the required 40 hours of pre-service training to new employees. The facility has hired eight new employees since the start of 2021. Background checks had been conducted on the new employees, consistent with new additions to County Detention Standards related to hiring decisions and consistent with PREA standards. The facility has begun conducting background checks on employees who have been with the agency more than five years. That project is ongoing. Samples of training records were reviewed and included required PREA training. The facility utilizes Relias for staff PREA training.

The facility has a draft of a new policy and procedure manual, as the current manual is outdated and inconsistent with current vision and practice. The new manual has yet to be approved. One of the new policies is a comprehensive PREA-specific policy.

Recommendations

Section	Recommendations
Admissions Policies and Procedures	• Eliminate the use of strip searches as a standard process during intake. • Implement the PREA Risk for Victimization Assessment for youth within 72 hours of admission and periodically throughout a youth's confinement. • Hire a PREA Officer to supervise facility compliance with PREA standards.
Personnel	• Budget for more supervisory staff to ensure adequate coverage is maintained. • Ensure a supervisor is present for all shifts during youth waking hours. • Alter supervisor schedules to maximize coverage throughout the week. • Alter counselor schedules to maximize coverage throughout the week.
Discipline	• Eliminate the use of "shifts" as a behavioral consequence and replace them with a short-term timeout process that releases youth as soon as they demonstrate they are calm and able to return to programming. • Eliminate the current practices associated with Administrative Plans and the Harvest Wing.

	• Ensure youth have adequate bedding and materials in their rooms. • Implement policy that prohibits the use of confinement longer than 4 hours without administrator approval and development of an individualized plan. • Enhance the documentation of youth confinement time to include: o Written reports that indicate the reason for confinement. o The start and end times of the confinement. o Attempts to de-escalate the youth and return them to regular programming. • Immediately end any practice of turning off water as a preventative measure and implement a policy that prohibits this practice. • Revise training materials and policy to explicitly prohibit the use of pain compliance and pressure point control.
Education	• Hire a sufficient number of teachers, including special education teachers, to ensure the required ratios for general and special education are met. • Identify a process to have a substitute teacher in the event of a teacher absence. • Adjust the daily schedule to provide 5 hours of education to all youth each day.
Medical and Health Care Services	• Hire or contract with a medical doctor. o Have a facility medical physician provide written approval to the facility before nonmedical staff can issue over-the-counter medication. • Hire or contract with an entity to provide psychiatric and/or psychological services.
Mental Health Services	• Employ or contract with qualified mental health professionals to provide mental health services to youth at the facility. o Provide a mental health assessment for all youth. o Develop and implement service plans for all youth with mental health needs.
Clothing, Personal Hygiene, Grooming	• Purchase new sets of clothing and discard any clothing that is damaged or stained. • Provide youth with the feminine hygiene products that are requested. • Provide all youth with shirts and sweatshirts. • Permit youth to shave as often as desired.
Sanitation	• Implement a tracking and monitoring process to ensure the cleaning of youth rooms matches the established schedule.
Youth Grievances	• Make grievance forms available to youth without having to obtain one from a staff member. • Place youth grievance boxes in youth living units and common areas.
Food Services	• Implement a policy that specifically states all youth are to be delivered the same meal regardless of behavior status unless directed by medical personnel.

	• Limit the use of Dining Area Restrictions to instances where security or medical needs prohibit the serving and conducting of meals in a group setting. • Serve three meals on Sundays.

Exhibit 6

Knox County Follow-up Visit

The Department of Juvenile Justice conducted an annual inspection of Mary Davis Home in Knox County on February 23, 2022, pursuant to 730 ILCS 5/3-15-2(b). The Department observed several areas on non-compliance during this review, many of which warranted immediate attention.

The Department of Juvenile Justice conducted a follow-up inspection to assess facility progress towards the noncompliant areas on June 28, 2022. There were some improvements noted, but several areas on noncompliance remain.

The table below summarizes the areas of non-compliance and recommendations from the February 23, 2022, inspection, along with the observations from the June 23, 2022, follow-up visit.

Section	Recommendations from February 23, 2022, Inspection	Follow-up Visit Notes – June 28, 2022
Admissions Policies and Procedures	• Eliminate the use of strip searches as a standard process during intake. • Implement the Prison Rape Elimination Act (PREA) Risk for Victimization Assessment for youth within 72 hours of admission and periodically throughout a youth's confinement. • Hire a PREA Officer to supervise facility compliance with PREA standards.	Administrators, staff, and youth all reported that the intake strip search is no longer occurring. Strip searches are only done if there is an individualized reason and with administrator approval. Since the facility made this change, there has not been a strip search conducted in the facility. A sample of youth files were reviewed. PREA Risk Assessments were present.
Personnel	• Budget for more supervisory staff to ensure adequate coverage is maintained. • Ensure a supervisor is present for all shifts during youth waking hours. • Alter supervisor schedules to maximize coverage throughout the week. • Alter counselor schedules to maximize coverage throughout the week.	The facility has hired a 4th supervisor and reports a 5th supervisor position has been approved by the Administrative Office of Illinois Courts (AOIC) and will be posted shortly. The addition of the 4th supervisor and changes to the staff schedule has helped decrease the number of times the facility is without a supervisor during waking hours. The facility is making progress towards compliance.
Discipline	• Eliminate the use of "shifts" as a behavioral consequence and replace them with a short-term timeout process that releases youth as soon as they demonstrate they are calm and able to return to programming.	Staff and youth interviews indicated the water shut off practice has been eliminated and is only used temporarily when youth are actively flooding their rooms. A formal policy prohibiting the practice has not yet been developed.

	• Eliminate the current practices associated with Administrative Plans and the Harvest Wing.
	• Ensure youth have adequate bedding and materials in their rooms.
	• Implement policy that prohibits the use of confinement longer than 4 hours without administrator approval and development of an individualized plan.
	• Enhance the documentation of youth confinement time to include:
	  ○ Written reports that indicate the reason for confinement.
	  ○ The start and end times of the confinement.
	  ○ Attempts to de-escalate the youth and return them to regular programming.
	• Immediately end any practice of turning off water as a preventative measure and implement a policy that prohibits this practice.
	• Revise training materials and policy to explicitly prohibit the use of pain compliance and pressure point control.
		Administrative staff reported the use of "shifts" has ended, however youth interviews, staff interviews, and documentation indicated the use of shifts is still in place at the facility. In one case from the week prior, a youth made a disrespectful comment to a supervisor during dinner. Documentation indicated the youth was confined during recreation the rest of the evening and the following day during first shift. In another case, a youth was discovered to have too many magazines in his room. He was confined in his room until 3pm the following day. There was also a youth who reported he initially refused to come out of his room at the morning wake-up time. His consequence was room confinement for the entire day.
		
		There are two youth at the facility housed in the Harvest Wing of the facility, one of which was present in the same room during the February visit. While both youths were out of their rooms working on educational materials individually in the day room, staff and youth reports indicate the youth have largely remained on a segregation status for much of their stays, characterized by significant amounts of confinement time with limited recreation time individually. The bedding in both rooms appeared similar to the February visit. Neither youth had a pillow and both youths' mattresses were in states of disrepair.
		
		Policy and training materials have yet to be updated. Staff indicated they were aware of the findings from the February visit but have not received training on any new procedures. Resident orientation materials still reference the use of shifts as a consequence, including materials in the file for youth intake a few days prior to the visit.
		
		In summary, there has been little improvement on the February findings in this area. Mary Davis Home remains significantly out of compliance with this section of the County Detention Standards and should take immediate action to come into compliance.

Education	• Hire a sufficient number of teachers, including special education teachers, to ensure the required ratios for general and special education are met. • Identify a process to have a substitute teacher in the event of a teacher absence. • Adjust the daily schedule to provide 5 hours of education to all youth each day.	Facility administrators have attempted to work with the school district to provide additional educational resources. The school district submitted a proposal that called for removing the teacher and replacing him with an instructional aid to assist youth in completing work through the credit recover program Edgenuity. While providing youth access to Edgenuity is a good thing, removal of the direct instruction teacher is not acceptable. On the date of the visit, some youth were attending school in the classroom, while others worked on packets in the program space. The facility remains out of compliance with the County Detention Standards as only one teacher is still available.
Medical and Health Care Services	• Hire or contract with a medical doctor. ○ Have a facility medical physician provide written approval to the facility before nonmedical staff can issue over-the-counter medication. • Hire or contract with an entity to provide psychiatric and/or psychological services.	Improvement in this area is in progress. The facility has contracted with Advanced Correctional Healthcare to provide medical services for youth. A one-year contracted started on July 20, 2022. It includes 20 hours per week of nursing coverage, telehealth, and a licensed physician.

Mental Health Services	• Employ or contract with qualified mental health professionals to provide mental health services to youth at the facility.
	  ○ Provide a mental health assessment for all youth.
	  ○ Develop and implement service plans for all youth with mental health needs.
		Improvements in this area are in progress. The July 20, 2022, contract with Advanced Correctional Healthcare include 12 hours per week of coverage by a Qualified Mental Health Practitioner. Advanced Correctional Healthcare has not been able to fill the position, however, so these hours are not yet being provided. Despite the efforts to secure a contract, the facility remains out of compliance in this area.

Clothing, Personal Hygiene, Grooming	• Purchase new sets of clothing and discard any clothing that is damaged or stained. • Provide youth with the feminine hygiene products that are requested.	Youth clothing was observed to be of acceptable quality during the visit. There were no further complaints regarding feminine hygiene products.

	• Provide all youth with shirts and sweatshirts. Permit youth to shave as often as desired.	
Sanitation	• Implement a tracking and monitoring process to ensure the cleaning of youth rooms matches the established schedule.	Youth rooms appeared clean during inspection, but there is not a formal process for tracking and monitoring adherence to a cleaning schedule.
Youth Grievances	• Make grievance forms available to youth without having to obtain one from a staff member. • Place youth grievance boxes in youth living units and common areas.	The facility had grievance forms available and a locked grievance box was present in the main programming space.
Food Services	• Implement a policy that specifically states all youth are to be delivered the same meal regardless of behavior status unless directed by medical personnel. • Limit the use of Dining Area Restrictions to instances where security or medical needs prohibit the serving and conducting of meals in a group setting. • Serve three meals on Sundays.	The facility has mandated that all youth receive the same meal regardless of behavior status. There are occasions in which some youth eat in the main programming space instead of the dining room, which is an improvement from the individual confinement that was associated with the Dining Area restrictions in February. Three meals are now being served on Sundays.

Exhibit 7

2023

2023 Knox County Juvenile Detention Center Inspection Report

JOHN ALBRIGHT

CHIEF OF PERFORMANCE AND INNOVATION

Executive Summary

The Department of Juvenile Justice conducted an annual inspection of Mary Davis Home in Knox County on April 3, 2023, pursuant to 730 ILCS 5/3-15-2(b). While there were some improvements noted from the 2022 Inspection Report, there remain several areas of non-compliance. The sections and specific requirements of the 20 Ill. Adm. Code 2602 County Juvenile Detention Standards ("County Detention Standards") noted as non-compliant are listed in the table below, while specific observations are noted in the following sections of this report. Each section of the report also includes policy and practice recommendations to either gain compliance or move towards best practice. Those recommendations are combined in a second table at the end of the report.

Areas of Non-Compliance

Section	Requirement
2602.170 Discipline	When the use of force is authorized, only the least force necessary under the circumstances shall be employed. . . The facility shall have written policy and procedures that clearly define the parameters for use of force. Use of force must be used as a last resort after de-escalation and other strategies have failed. Staff must be trained in acceptable methods of physical intervention. . . Use of force must be limited to those situations where a youth's behavior is an immediate threat to themselves or to others. . . Room confinement may be used only as a temporary response to behavior that threatens the safety of the youth or others. . . Room confinement shall not be used for a fixed period of time, but only until the youth is calm enough to rejoin programming without being a risk to the safety of others.
2602.230 Education	Each facility must designate a qualified educational authority responsible for the development and implementation of the educational program. . .Teacher student ratios are at least 1:12 for general education and 1:8 for students with Individualized Education Programs (IEPs). Qualified special education staff are assigned to youth with special education status and special education testing is available for youth in custody. There shall be a minimum of five hours of instruction per day.
2602.50 Admissions Procedures	Clothing and other garments shall be of an appropriate size and in a state of good, usable condition.
2602.90 Mental Health Services	All facilities shall employ or contract with qualified mental health professionals to address the needs of youth identified in the mental health screening, as well as needs that arise during the period of confinement. Services shall meet or exceed the community level of care.

Methodology

- Interviews Conducted
  - Superintendent Steck
  - Director Pletz

  - Assistant Superintendent Bonis
  - Educator
  - 5 youth
  - Shift Supervisor
  - 3 Counselors

- Documents Reviewed
  - Youth Grievance Samples
  - Use of Force Continuum Policy
  - Client Grievance Policy
  - Client Linens and Clothing Policy
  - Daily Programming Schedules
  - Dietary Menus
  - Youth Handbook
  - Food Services Policy
  - Health Department Inspection Results
  - Intake Searches Policy
  - Nursing License
  - Educator License
  - Mental Health Screening Interview Template

Overview

Mary Davis Home is a 39-bed facility in Galesburg, Illinois. The primary programming space is a large common area that is centrally located between the four primary living units (referred to as Upper East, Lower East, Upper West, and Lower West). There is an additional living unit called the "Harvest Wing" in a corridor off the main programming area that has three additional rooms, one of which has a camera. The facility has a gym space just off the primary programming space with a large window separating the two areas. A single classroom is off the main area as well. The classroom is quite large and was decorated in a manner consistent with a community school. The facility has an extensive library with several books available for youth.

The facility has continued offering in-person visitation two nights a week. The visitation area is sizable and has some artwork, including a mural that was recently completed by a local community college. It is commendable that the facility has continued offering in-person visitation and has a welcoming space to host. The facility also has video conferencing capability and has utilized it for court and professional visits. Video conferencing has not yet been offered for family visitation, but administrators reported plans to use video conferencing for family visits in coming months. It should be noted that administrators reported these same plans during the February 2022 inspection, but they have yet to be implemented.

The on-site portion of the review took place on Monday, April 3, 2023. At the time of the audit, the facility had 19 residents.

Admission Policy and Procedures

Mary Davis Home offers 24-hour coverage for admissions. Youth property is collected, inventoried, and laundered according to standards. During the facility walkthrough, auditors observed the property room in which youth personal clothing was organized into bins by youth. Inventory receipts were present in the bins with clothing, as well as youth files. The facility has made changes to their admission policies to come into compliance with County Detention Standards by eliminating the use of strip searches as standard practice during the intake process. Youth at the facility affirmed they were not strip searched upon intake.

An initial orientation is conducted by a counselor during the intake process. The facility has a Youth Orientation Manual that includes a broad overview of programming and rules. Some youth indicated a lack of understanding about expectations after the initial orientation and learned more from their peers in the days following admission. There are opportunities to enhance the youth orientation process to make it less transactional and more robust.

Medical screenings are conducted by the facility nurse, who consults with parents over medical history and medications. The nurse also inspects medications that youth bring into the facility and coordinates with a physician to approve prescriptions.

The facility has not undergone an official PREA audit. It would be beneficial to hire a PREA Officer to ensure there is an internal mechanism for monitoring facility compliance with PREA standards.

Areas of Non-Compliance and Recommendations

- Recommendation:
    - Hire a PREA Officer to supervise facility compliance with PREA standards.

Personnel, Staffing and Supervision

Maintaining sufficient staffing levels at the facility has been a challenge over the past year. In order to attract applicants, Mary Davis Home requested and was approved for a waiver to the bachelor's degree hiring requirement by the Administrative Office of Illinois Courts (AOIC). The facility now only requires 60 college credit hours or an associate's degree to qualify for employment. Knox County also increased the starting salary for Counselors by 10% to $44,000/year. At the time of the audit, the facility employed 19 Counselors and five Supervisors (one of whom is a "floating" supervisor that also conducts Risk for Victimization Assessments for new intakes). A typical shift includes five or six staff members (including a supervisor) which is sufficient given the average size of youth population. While the Mary Davis Home has struggled to maintain desired staffing levels, they have been able to maintain a sufficient enough level to maintain normal operations. While there is some misuse of youth confinement noted later in the report, it has not been driven by lack of staffing at the facility.

New employees receive 20-24 hours of training remotely through the AOIC Relias System and the AOIC Detention Basic Training. The facility has two certified Handle with Care trainers on staff who provide de-escalation and use of physical intervention trainings.

Detention Programs, Youth Discipline, and Confinement

Counselors facilitate regular daily Life Skills Groups. The content of the groups is largely determined by the staff facilitating the group, although some of the groups are designated as Social Skills Groups and use the Boys Town Social Skills Training Curriculum. On the day of the inspection, the auditor observed a group facilitated by a Counselor with five youth on the topic "Dealing with Authority Issues." There is also programming offered by some volunteer groups, including a weekly art class and bi-weekly movement class, both offered through the Civic Art Center of Galesburg. A local church group also offers religious programming once per week on Fridays.

The facility utilizes a point grading system to track youth behavior. Youth are graded on an A through F scale at the end of each shift. Grades are averaged daily and shared with youth at the start of the following day. The averaged grade is associated with certain privileges, such as later bedtime, candy bars, and extra visits. Youth on the highest level are permitted to stay up until midnight one night per week to watch movies.

The use of confinement continues to be prevalent at the facility. On the day of the audit, the auditor went into the residential side of the facility at 9:45am. Upon arrival, one youth was visiting with a probation officer, and another was engaged in a counseling session. All other youth were confined in their rooms for "cleaning time." This stands in contrast to the daily schedules that were submitted in advance of the audit that indicate room cleaning should have ended by either 8:30 or 9:00am. Youth were released from their rooms at approximately 10:00am. Some youth were brough into the facility classroom for a group conducted by one of the Detention Officers. The rest were given free time.

There were frequent times throughout the day that youth were confined unnecessarily. A white board in the dayroom listed times youth were required to return to their rooms (by grade level) for little apparent reason:

Grade D – 10:50am
Grade C – 11:00am
Grade B – 11:15am
Grade A – 11:30am

Essentially, youth were only out of their rooms for programming between 50-90 minutes before lunchtime. The auditor returned to the area at 12:00pm. Youth were still confined in their rooms and later brought out in small groups to eat lunch, after which they returned to their rooms again. During this timeframe several staff members were observed grouped together in the common area and did not appear to be engaged in any tasks. There did not appear to be any reason for the youth to be confined in the manner they were.

Youth report, staff report, and documentation all indicated that the practice of rotating youth in and out of confinement is common at the facility, particularly on the second shift. Several youth reported spending extended periods of times confined during evening shifts, only coming out of their rooms for

dinner and an hour of recreation time rotated amongst groups of youth. This was confirmed by some documentation, including the shift log that documented the rotating confinement hours from previous shifts. This practice of rotating youth in and out of confinement throughout the day with no behavioral justification is out of compliance with County Detention Standards.

While the facility has made some improvements to the approach towards behavioral confinement, the use of confinement continues to be used excessively as a behavioral consequence. On a positive note, the facility ended the practice of assigning "shifts" as outlined in the 2022 inspection report. The facility has also incorporated the use of cognitive-behavioral interventions with the use of confinement. In several instances, youth have been asked to complete thinking reports, engage in 1:1 counseling sessions with staff, and participate in groups with other youth as part of individual plans. The facility also maintains a record of confinements and packets completed by youth. These changes are certainly positive, however further improvements are needed. The use of "shifts" has been eliminated and the facility has implemented the use of "Behavior Holds" as a response to negative behavior. The facility "Detention Level Program Manual" indicates a behavior hold constitutes a youth being placed in their room for a short period of time. It also indicates youth will return to programming once they have "calmed down." In practice, however, behavioral holds are confinements that last for more than one day. A review of documentation indicated these behavioral holds typically last for at least 24 hours, during which youth complete a thinking report, engage in a required 1:1 meeting, and participate in groups while being confined during most other times. As noted above, the incorporation of cognitive-behavioral interventions is a good thing, however the length of confinement time is unnecessary and does not meet the facility's stated intention to end a behavior hold as soon as a youth calms down. It is clear that the institutional understanding of these behavior holds is that they last for an entire day. On the day of the inspection, one youth was still on a behavior hold from an event the morning prior. In the logbook, it was documented that the youth had been placed on a behavior hold at 11:00am the day prior. At 12:00pm, there was an entry stating the youth's father had been called by staff to cancel a visit scheduled with the youth for 3:30pm that day. This is problematic for two reasons. First, it indicated the youth's behavior hold was assumed to last more than 4.5 hours, and second, the visit was cancelled as part of a consequence. Both violate County Detention Standards.

On the date of the inspection there were two youth housed in the facility "Harvest Wing," a small hallway of rooms off the main programming area. While they were incorporated into regular programming with the rest of the youth throughout the day, it was apparent youth are still being housed in the Harvest Wing as a consequence. In one instance, a youth had been moved to the Harvest Wing involuntarily through the use of physical intervention after making too much noise in his room at night. Despite the youth being in his room presenting no risk to himself or his peers, staff entered his room and engaged the youth in physical intervention solely for the purpose of moving the youth to the Harvest Wing. An employee was injured during the intervention. The decision-making in this situation is demonstrative of poor practice, as there is no indication the youth was a risk to himself or others while being "noisy" in his room.

The facility policy that governs the use of force does not include any language that stipulates when the use of force is permitted. The policy should be updated to only permit the use of force when a youth's behavior is an immediate threat to themselves or others. Since the time of the audit, the facility has

made changes to the use of the Harvest Wing and recently drafted a policy prohibiting use of the rooms in the Harvest Wing for youth housing. Facility Administrators have indicated they plan to turn it into an additional programming space.

Since the 2022 Inspection Report, the Mary Davis Home has transitioned to Handle with Care as the primary physical restraint technique used at the facility. The facility has also updated the Use of Force Continuum Policy to strictly prohibit the use of pain compliance and pressure point control with youth. During youth interviews, however, some youth expressed some complaints about the use of physical intervention at the facility, one of which occurred the previous day. The auditor and the facility superintendent reviewed video footage of the incident and there were some items of concern observed, enough to prompt a report to the Department of Children and Family Services. It was further noted that one of the staff members involved in the incident had not received training on Handle with Care, the facility's physical intervention process.

Areas of Non-Compliance and Recommendations

- 2602.170 Discipline states: "When the use of force is authorized, only the least force necessary under the circumstances shall be employed. . . The facility shall have written policy and procedures that clearly define the parameters for use of force. Use of force must be used as a last resort after de-escalation and other strategies have failed. Staff must be trained in acceptable methods of physical intervention. . . Use of force must be limited to those situations where a youth's behavior is an immediate threat to themselves or to others. . . Room confinement may be used only as a temporary response to behavior that threatens the safety of the youth or others. . . Room confinement shall not be used for a fixed period of time, but only until the youth is calm enough to rejoin programming without being a risk to the safety of others."
    - Recommendations:
        - Revise the Use of Force Policy to stipulate the use of force is limited to situations where a youth's behavior is an immediate threat to themselves or others.
        - Ensure all staff are trained on the use of force, de-escalation, and physical restraint techniques.
        - Allow youth to spend the entire programming day outside of their rooms during normal waking hours.
        - Adjust the behavior hold process to limit room confinement to a temporary response to behavior until a youth is calm enough to rejoin programming.

Medical and Health Care

There is one nurse that works at the facility five days per week for four hours each day. The facility has a sick call process by which a youth can request to be added to the sick call list, which is maintained in the control room to be given to the nurse upon her arrival. All youth receive a physical within seven days of admission. A physician is on-site a few times each month as needed and available for consultation.

Mental Health Services

Upon intake, all youth are administered a Massachusetts Youth Screening Instrument (MAYSI) by administrative staff. Scores on the MAYSI play a role in determining if youth are checked at a frequency of 10 or 15 minutes.

Last year the facility entered into a contract with Advanced Healthcare Solutions (ACH) to provide 20 hours of mental health services to youth per week. ACH has had difficulty hiring a Mental Health Professional (MHP) specific for the detention center, so they have a social worker from the Peoria County Juvenile Detention Center commute to the Mary Davis Home twice per week to provide services for youth for approximately seven total hours. The MHP reported most of her work at Mary Davis Home consists of seeing any youth who are on a crisis status, checking in on any youth who are on a special behavior plan, or youth who have requested to see her. She reported she attempts to conduct an assessment on all youth intakes but has been unable to do so given the limited number of hours she has at the facility. Treatment plans are not being developed for any youth and she does not carry a formal caseload. In short, the mental health services provide to youth at Mary Davis Home appear to be limited to responding to day-to-day needs rather than an assessment-driven treatment plan.

The contract with ACH is an improvement over the state of mental health services from the 2022 Inspection Report, however the services provided for youth are still inadequate and out of compliance with County Detention Standards. It should be noted that since the time of the inspection, a mental health practitioner has started at the facility and is providing 20 hours of services each week. The MHP started in late June of 2023.

Areas of Non-Compliance and Recommendations

- 2602.90 Mental Health Services states: “All facilities shall employ or contract with qualified mental health professionals to address the needs of youth identified in the mental health screening, as well as needs that arise during the period of confinement. Services shall meet or exceed the community level of care.”
    - Recommendations
        - Provide a mental health assessment for all youth.
        - Develop and implement service plans for all youth with mental health needs.

Clothing, Personal Hygiene, Grooming

The facility issues clothing to youth. Clothing and undergarments are scheduled to be laundered every day, a task that is managed by the overnight shift. The overnight shift is also responsible for discarding any clothing items that are damaged or stained.

The quality and cleanliness of clothing was a consistent complaint from residents and the auditor observed poor quality as well. One youth was observed wearing pants with a large hole in it, and several youth were wearing sweatshirts with bleach stains. The poor quality of clothing is a repeat finding from the 2022 inspection.

Areas of Non-Compliance and Recommendations

- 2602.50 Admission Procedures states: "Clothing and other garments shall be of an appropriate size and in a state of good, usable condition."
    - Recommendations:
        - Ensure youth are provided clothing in a good state and free of holes and/or stains.

Food Services

Mary Davis Home has a kitchen on-site and employs one full-time cook. The facility offers three meals per day and a snack to youth seven days per week. The facility maintains a record of menus and any alterations. A list of youth with special diets was posted in the kitchen. The facility had protein options present for youth on vegetarian diets, however there were complaints by some youth that these options have not been present throughout their stay. The facility does utilize one resident as a youth worker in the kitchen to assist with clean-up.

Education

The facility has one full-time teacher on-site from the Galesburg school district. Upon a youth's admission, the facility Assistant Superintendent reaches out to a youth's home school to obtain educational records and communicate to ensure youth get credit for educational services provided at the facility. The classroom itself is well-equipped and a welcoming space. Youth at the facility were very complimentary of the teacher, stating he is engaging and enjoyable to learn from. The daily education schedule provides five hours of educational services each day.

The County Detention Standards stipulate that the teacher-student ratio for general education needs to be 1:12 and 1:8 for special education students. Given the youth population size (19 on the day of the audit), the facility does not meet the required ratios. The facility reports they cap the number of youth in the classroom at 12 at any given time and provide educational packets to remaining youth, however this is not the strategy to employ in order to meet the standard. To meet the standard, a sufficient number of general education and special education teachers need to be available at the facility to provide quality education to the entire population of youth. Furthermore, while the youth at the facility are very complimentary of the one teacher that does work at the facility, that teacher is not properly licensed to teach high school. The teacher is only licensed to teach K-9. There is no special education teacher at the facility.

Facility administrators report they have made attempts to obtain additional educator resources through the Galesburg school district but have been denied.

Areas of Non-Compliance and Recommendations

- 2602.230 Education states: "Each facility must designate a qualified educational authority responsible for the development and implementation of the educational program. . .Teacher student ratios are at least 1:12 for general education and 1:8 for students with Individualized Education Programs (IEPs). Qualified special education staff are assigned to youth with special

education status and special education testing is available for youth in custody. There shall be a minimum of five hours of instruction per day."

- Recommendations:
  - Hire a sufficient number of teachers, including special education teachers, to ensure the required ratios for general and special education are met.
  - Identify a process to have a substitute teacher in the event of a teacher absence.
  - Ensure all teachers are properly licensed.

Recommendations

Section	Recommendations
Admissions Policies and Procedures	• Hire a PREA Officer to supervise facility compliance with PREA standards. • Ensure youth are provided clothing in a good state and free of holes and/or stains.
Discipline	• Revise the Use of Force Policy to stipulate the use of force is limited to situations where a youth's behavior is an immediate threat to themselves or others. • Ensure all staff are trained on the use of force, de-escalation, and physical restraint techniques. • Allow youth to spend the entire programming day outside of their rooms during normal waking hours. • Adjust the behavior hold process to limit room confinement to a temporary response to behavior until a youth is calm enough to rejoin programming.
Education	• Hire a sufficient number of teachers, including special education teachers, to ensure the required ratios for general and special education are met. • Identify a process to have a substitute teacher in the event of a teacher absence. • Ensure all teachers are properly licensed.
Mental Health Services	• Provide a mental health assessment for all youth. • Develop and implement service plans for all youth with mental health needs.

Exhibit 8

2024

2024 Knox County Juvenile Detention Center Inspection Report

JOHN ALBRIGHT, CHIEF OF PERFORMANCE AND INNOVATION

ILLINOIS DEPARTMENT OF JUVENILE JUSTICE

Executive Summary

The Department of Juvenile Justice conducted an annual inspection of Mary Davis Home in Knox County on February 27, 2024, pursuant to 730 ILCS 5/3-15-2(b). While there were some improvements noted from the 2023 Inspection Report, there remain areas of non-compliance. The sections and specific requirements of the 20 Ill. Adm. Code 2602 County Juvenile Detention Standards ("County Detention Standards") noted as non-compliant are listed in the table below, while specific observations are noted in the following sections of this report. Each section of the report also includes policy and practice recommendations to either gain compliance or move towards best practice. Those recommendations are combined in a second table at the end of the report.

Areas of Non-Compliance

Section	Requirement
2602.170 Discipline	Room confinement may be used only as a temporary response to behavior that threatens the safety of the youth or others. . . Room confinement shall not be used for a fixed period of time, but only until the youth is calm enough to rejoin programming without being a risk to the safety of others.
2602.230 Education	Each facility must designate a qualified educational authority responsible for the development and implementation of the educational program. . .Teacher student ratios are at least 1:12 for general education and 1:8 for students with Individualized Education Programs (IEPs). Qualified special education staff are assigned to youth with special education status and special education testing is available for youth in custody. There shall be a minimum of five hours of instruction per day.

Methodology

- Interviews Conducted
  - Superintendent Steck
  - Assistant Superintendent
  - Director Pletz
  - Educator
  - 4 youth
  - Shift Supervisor
  - 4 Counselors
  - Mental Health Professional

- Documents Reviewed
  - Use of Force Continuum Policy
  - Detention Tier Program Policy
  - Timeouts and Behavior Hold Policy
  - Client Grievance Policy
  - Detention Tier Program (DTP) Handbook

- Youth Orientation Materials
- Sample Incident Reports
- Youth Grievance Samples
- Daily Programming Schedules
- Dietary Menus
- Nursing License
- Educator License
- Mental Health Screening Interview Template
- Sample Youth File
- Daily Programming Log
- Prison Rape Elimination Act (PREA) Policies

Overview

Mary Davis Home is a 39-bed facility in Galesburg, Illinois. The primary programming space is a large common area that is centrally located between the four primary living units (referred to as Upper East, Lower East, Upper West, and Lower West). There is an additional living unit called the "Harvest Wing" in a corridor off the main programming area that has three additional rooms, one of which has a camera. Since the 2023 inspection, the facility has stopped using the Harvest Wing to house residents; utilizing the area for commissary purchases, virtual court, and a meeting space for youth and mental health staff. The facility has a gym space just off the primary programming space with a large window separating the two areas. A single classroom is off the main area as well. The classroom is quite large and decorated in a manner consistent with a community school. The facility has an extensive library with many books available for youth. The library space has been moved over the past year to make it more accessible for residents.

The facility offers in-person visitation two nights a week. The visitation area is sizable and has some artwork, including a mural that was recently completed by a local community college. It is commendable that the facility has continued offering in-person visitation and has a welcoming space to host youth visits. The facility has video conferencing capability that it utilizes for court and professional visits. Video conferencing is now offered for family visitation, especially for youth with families that live out of the area.

The on-site portion of the review took place on Tuesday, February 27, 2024. At the time of the audit, the facility had 12 residents. The facility typically averages more than 20 youth in facility. As the facility has been short-staffed, the superintendent has tried to keep resident numbers at lower levels.

Administrators are pursuing some infrastructure improvements, including entering into a contract to have new cameras and a new security system installed. There is also a project to have new floor tiles installed.

Admission Policy and Procedures

Mary Davis Home offers 24-hour coverage for admissions. Youth property is collected, inventoried, and laundered according to standards. During the facility walkthrough, auditors observed the property room in which youth personal clothing was organized into bins by youth. Inventory receipts were present in the bins with clothing, as well as youth files. The facility has made changes to their admission policies to come into compliance with County Detention Standards by eliminating the use of strip searches as standard practice during the intake process; instead, only utilizing strip searches when there is an individualized suspicion of contraband. Youth intakes are searched via a wand and pat-down.

Mary Davis Home has implemented several policies related to the Prison Rape Elimination Act over the past year. Within a day of admission, all youth intakes receive a risk assessment for sexual victimization administered by the superintendent or supervisor. These assessments were present in youth files. An initial orientation is conducted by a counselor during the intake process, inclusive of youth rights related to the Prison Rape Elimination Act. Youth sign-off on receipt of the orientation was also observed in youth files. All interviewed youth were familiar with PREA. The facility Youth Orientation Manual includes a broad overview of programming and rules. While the facility has implemented many of the PREA requirements incorporated into the County Detention Standards, a formal PREA audit has yet to be completed.

Medical screenings are conducted by the facility nurse, who consults with parents about medical history and medications. The nurse also inspects medications that youth bring into the facility and coordinates with a physician to approve prescriptions.

Personnel, Staffing and Supervision

Maintaining sufficient staffing levels at the facility has been a challenge over the past few years. In order to attract applicants, Mary Davis Home requested and was approved for a waiver to the bachelor's degree hiring requirement by the Administrative Office of Illinois Courts (AOIC). The facility now only requires 60 college credit hours or an associate's degree to qualify for employment. Knox County also increased the starting salary for Counselors to $46,155/year. At the time of the audit, the facility employed 24 Counselors and five Supervisors (one of whom is a "floating" supervisor that conducts Risk for Victimization Assessments for new intakes). A typical shift includes five or six staff members (including a supervisor) which is sufficient given the average size of the youth population within the facility.

New employees receive 20-24 hours of training remotely through the AOIC Relias System and the AOIC Detention Basic Training. The facility has two certified Handle with Care trainers on staff who provide de-escalation and use of physical intervention trainings. The facility is also seeking to convert one Counselor position to a full-time trainer and PREA Coordinator.

Detention Programs, Youth Discipline, and Confinement

The facility has increased the amount of programming available to youth over the past year. A Youth in Christ community program comes on Friday afternoons for religious and sports programming. Counselors continue to facilitate groups four nights per week. The content of the groups is largely determined by the staff facilitating the group, although some of the groups are designated as Social Skills Groups and use the Boys Town Social Skills Training Curriculum.

Since the 2023 Inspection, the facility has implemented a new behavior program, adapted from programs run at other county detention centers. The new behavior program consists of a "Tier System" with three behavior levels. Residents move to different levels based on a daily behavior point card. The facility has also instituted a commissary system. Youth earn "Mary Money" for exhibiting positive behaviors and can redeem Mary Money through the "Mary Mart" which consists of snacks and hygiene products. The new behavior management system is a marked improvement to the previous one, and philosophically more consistent with County Detention Standards.

The facility has made improvements towards the use behavioral confinement since the 2022 and 2023 Inspection Reports; however, the use of confinement remains out of compliance with County Detention Standards. The closure of the Harvest Wing is an important step for the facility as it eliminates use of the space that was commonly used as a segregation wing at the facility. The facility continues to employ use of a "Special Group Status (SGS)" for youth who engage in significant behaviors in the facility. SGS utilizes two youth levels. Level 1 consists of an initial behavior hold (a timeout longer than 15 minutes). The facility utilizes a new form to track frequent checks on the youth, the name of the person conducting the checks, and a description youth behavior justifying continued use of the behavior hold. The implementation of this method of tracking is another important step in reducing the use of youth confinement in the facility as, with proper monitoring and quality assurance, can help ensure youth are only confined until their behavior is deemed to no longer be a risk to themselves or others. The second SGS level is intended to consist of youth being off confinement working on special behavior plans approved by the superintendent or assistant superintendent. These plans include assignments from Carey Guides or other cognitive-behavioral assignments. In practice, youth are frequently kept on SGS for multiple days, and both youth and staff report a significant amount of confinement associated with youth on these statuses, particularly on the second shift when youth are not working on assignments.

The 2023 inspection noted frequent times throughout the day that youth were confined unnecessarily. This was again observed as youth are frequently moved in and out of their rooms during transition times such as after breakfast, before lunch, at shift change, and before lunch and dinner. These frequent confinements are unnecessary to maintain normal operations and add up to unnecessary youth confinement. On the day of the audit, there were only 12 youth in the facility with plenty of staff available to manage transitions without the use of these confinements.

Youth and staff reports indicate that the practice of rotating youth in and out of confinement continues to be common at the facility, particularly on the second shift. Youth and staff use the terms "split" or "switch" to indicate if youth are rotated amongst programming areas or take turns being confined .

Several youth reported only coming out of their rooms for dinner recreation time. . This practice is non-compliant with County Detention Standards.

Areas of Non-Compliance and Recommendations

- 2602.170 Discipline states: "Room confinement may be used only as a temporary response to behavior that threatens the safety of the youth or others. . . Room confinement shall not be used for a fixed period of time, but only until the youth is calm enough to rejoin programming without being a risk to the safety of others."
    - Recommendations:
        - Allow youth to spend the entire programming day outside of their rooms during normal waking hours.
        - Adjust the SGS process to limit room confinement to being used as a temporary response to behavior until a youth is calm enough to rejoin programming.

Medical and Health Care

There is one nurse that works at the facility five days per week for four hours each day. The facility has a sick call process by which a youth can request to be added to the sick call list, which is maintained in the control room to be given to the nurse upon her arrival. All youth receive a physical within seven days of admission. A physician is on-site a few times each month as needed and available for consultations.

Mental Health Services

Upon intake, all youth are administered a Massachusetts Youth Screening Instrument (MAYSI) by administrative staff. Scores on the MAYSI play a role in determining if youth are checked at a frequency of 10 or 15 minutes.

In 2022 the facility entered a contract with Advanced Healthcare Solutions (ACH) to provide youth 20 hours of mental health services per week. ACH initially had difficulty hiring a Mental Health Professional (MHP) specific for the detention center but were able to do so in the middle of 2023. That MHP is on-site 3-4 days per week for an average of 15 hours per week. A second MHP is scheduled to start in June, 2024 hours to provide five additional hours of mental health services. The current MHP does an intake assessment for new youth and reports any youth who are on SGS when the MHP is on-site. Per the MHP report, youth on SGS are almost always confined when the MHP meets with them and has little to do with the implementation of the SGS plan itself.

Food Services

Mary Davis Home has a kitchen on-site and employs one full-time cook, however the cook was out on leave at the time of the audit, causing all meals to be made by security staff. The lack of specialized dietary staff directly impacts the volume of security staff available to monitor youth, and does, at times, contribute to increased use of confinement at the facility. Per facility administrators, one new cook is scheduled to start in June, 2024.The facility offers three meals per day and a snack to youth seven days per week. The facility maintains a record of menus and any alterations to the dietary offerings.

Recommendations:

- Hire or contract with a vendor to provide sufficient coverage for dietary services to prevent the need to utilize security staff for food preparation.

Education

The facility has one full-time teacher on-site from the Galesburg school district. Upon a youth's admission, the facility Assistant Superintendent reaches out to a youth's home school to obtain educational records and communicate to ensure youth get credit for educational services provided at the facility. The classroom itself is welcoming and is well-equipped. Youth at the facility were very complimentary of the teacher, stating he is engaging and enjoyable to learn from. The daily education schedule provides five hours of educational services each day.

The County Detention Standards stipulate that the teacher-student ratio for general education needs to be 1:12 and 1:8 for special education students. Given the youth population size (an average of more than 20 youth), the facility does not meet the required ratios. The facility reports that the number of youth in the classroom is capped at 12. Youth over and above this amount are provided educational packets. This is not a strategy that meets the standard. The facility also reports they have implemented and "O.W.L." system which allows youth physically present in a living unit day room to participate in the lesson remotely, however this was not functional on the day of the audit. To meet the standard, a sufficient number of general education and special education teachers need to be available at the facility to provide quality education to the entire population of youth. Furthermore, while the youth at the facility are very complimentary of the one teacher that does work at the facility, that teacher is not properly licensed to teach high school. The teacher is only licensed to teach K-9. There is no special education teacher at the facility, however administrators report that a new, full-time special education teacher from the Galesburg School District will be starting at the facility in August, 2024.

Areas of Non-Compliance and Recommendations

- 2602.230 Education states: "Each facility must designate a qualified educational authority responsible for the development and implementation of the educational program. . .Teacher student ratios are at least 1:12 for general education and 1:8 for students with Individualized Education Programs (IEPs). Qualified special education staff are assigned to youth with special education status and special education testing is available for youth in custody. There shall be a minimum of five hours of instruction per day."
    - Recommendations:
        - Hire a sufficient number of teachers, including special education teachers, to ensure the required ratios for general and special education are met.
        - Identify a process to have a substitute teacher in the event of a teacher absence.
        - Ensure all teachers are properly licensed.

Recommendations

Section	Recommendations
Discipline	• Allow youth to spend the entire programming day outside of their rooms during normal waking hours. • Adjust the SGS process to limit room confinement to a temporary response to behavior until a youth is calm enough to rejoin programming.
Education	• Hire a sufficient number of teachers, including special education teachers, to ensure the required ratios for general and special education are met. • Identify a process to have a substitute teacher in the event of a teacher absence. • Ensure all teachers are properly licensed.
Food Services	• Hire or contract with a vendor to provide sufficient coverage for dietary services to prevent the need to utilize security staff for food preparation.

Exhibit 9

Summary of the Juvenile Detention Review: Mary Davis Home

Knox County

Standard Area	Rating • Exceeds • Meets, • Meets with Recommendations • Does not Meet
Section 1: Introduction	• Does not Meet
Section 3: Administration	• Does not Meet
Section 4: Admissions	• Does not Meet
Section 5: Programming	• Does not Meet
Section 6: Medical and Mental Health Services	• Does not Meet
Section 7: Release Planning	• Does not meet
Section 8: Documentation	• Does not Meet
Section 9: Resident Rights	• Does not Meet

Summary:

On July 25-27, 2022, a review of the Mary Davis Home (MDH) was completed by a four-member team from the Administrative Office of the Illinois Courts. While on site the team completed a review of policies and procedures, resident files, interviews of resident and staff and observations of daily activities of the facility. It was noted through the review process, MDH staff have great rapport with the youth in the facility and interact well with each other throughout the day. Parents can visit the residents through contact visitation as well as phone calls at scheduled times throughout the week. The facility continues to allow volunteers to meet with the residents for religious/spiritual services and recreational and educational programs were provided to the youth.

At the conclusion of the review, there were several areas that MDH would need to address to become compliant with the AOIC Juvenile Detention Standards. Consistent with the standards, the AOIC has identified the following actionable items for LCJDC to address.

- Full adherence to the Juvenile Detention Standards (2021), appellate court decisions, Prison Rape Elimination standards (PREA) and relevant statutes. *[Probation and Probation Officers Act 730 ILCS 110, Juvenile Court Act 705 ILCS 405,]*
- Safety and Security
- Administration and Training
- Programming
- Admissions and Release Planning
- Medical and Mental Health Services
- Resident Rights
- Documentation

A Corrective Action Plan (CAP) was sent to MDH by AOIC to create a plan and timelines for completion. Follow-up and technical assistance will be completed by the assigned Field Coordinator and members of the Detention Review Team.

Exhibit 10

June 01, 2023

Agreement No. 33-048-002P-00

Ms. Wendi Steck
County of Knox
1319 E 5th St
Galesburg, IL 61401-6698

Dear Ms. Wendi Steck :

Enclosed is the report of your School Nutrition Programs Meal Compliance and Accountability Review, conducted on May 24, 25, 2023. The report identifies the problems cited during the review and the corrective action recommended.

Due to the severity of the problems identified, County of Knox will receive a follow-up review.

A corrective action plan to the review report must be received in WINS within 30 days from the receipt of this letter. The response to each citation must detail specific actions taken to correct the problems cited.

Technical assistance materials and/or training opportunities may be available to assist in correcting the problems identified in the review. The cooperation of personnel during this review was appreciated.

If you have questions regarding your review, please contact Harley Hepner at hhepner@isbe.net. For all other questions, please contact our office at 800/545-7892.

Sincerely,

Mark R. Haller, SNS
Director
Nutrition Programs

Enclosure

CC: File

School Nutrition Programs
Meal Compliance and Accountability Review

This report summarizes the results of the meal compliance and accountability review for the School Nutrition Programs sponsored by the County of Knox, RCDT number 33-048-002P-00, conducted on May 24, 25, 2023, by Harley Hepner, Principal Consultant.

The results of the review were discussed at an exit conference on May 25, 2023, with

Sandra McDorman, Food Service/Cook

Wendi Steck, Superintendent

The purpose of the review was to monitor the sponsor's compliance with Federal and state program regulations. The following areas of program compliance were evaluated:

Afterschool Snack, if applicable

Certification and Benefit Issuance

Civil Rights

Dietary Specifications and Nutrient Analysis

Food Safety

Fresh Fruit and Vegetable Program, if applicable

Local School Wellness Policy

Meal Components and Quantities

Meal Counting and Claiming

Offer Versus Serve

On-Site Monitoring

Outreach

Professional Standards

Reporting and Recordkeeping

Smart Snacks

Special Milk Program, if applicable

Verification

Water

During the review, technical assistance was provided to the sponsor in the following areas:

Area(s) of Technical Assistance:

Food Safety

Local Wellness Policy

Meal Components and Quantities

Meal Counting and Claiming

Outreach

During the review, the following problems were identified. All other areas were found to be in compliance.

Site: Mary Davis Home (13511)

Meal Components and Quantities

Citation:

On the day of the on-site observation for breakfast and lunch, the portion size of the fruit served at both meal services did not meet meal pattern requirements. At breakfast , the minimum serving size of the fruit must be one cup daily for grades K-8 and at lunch one cup daily for grades 9-12.

Citation:

On the day of the on-site observation for breakfast and lunch, the site did not offer two fat-free options or a low-fat (1% milk fat or less) and a fat-free milk choices. Students must be offered the appropriate milk choices.

Citation:

The lunch menus for the selected week of review, April 17-21, 2023, were evaluated and the following daily portion size problems were identified:
1) The minimum grain/bread serving size was not offered on Tuesday for grades 9-12. A minimum of two ounce grain/bread equivalents must be offered on a daily basis for grades 9-12.
2) The minimum vegetable serving size was not offered on Monday and Wednesday through Friday for grades 6-8 and grades 9-12. A minimum of 3/4 cup vegetable must be offered on a daily basis for grades 6-8 and one cup vegetable daily for grades 9-12.
3) The minimum fruit serving size was not offered on Monday through Friday for grades 9-12. A minimum of one cup fruit must be offered on a daily basis for grades 9-12.
Appropriate documentation must be available to validate the contributions of the food items to the meal pattern requirements.

Citation:

Lunch production records for the selected week of review, April 17-21, 2023, were evaluated and the following problems were identified:
1) All specific foods served were not included.
2) The recipe or product name was not recorded for all foods.
3) The grade group were not recorded.
Production records must accurately reflect the specific foods/condiments used, recipe or product name, grade groups, portion sizes, student and total projected servings, amount of food used, and the number of leftovers.

Citation:

Daily portion size issues were found with the selected week of review, April 17-21, 2023, breakfast menus and it was determined that the minimum fruit serving size was not offered on Monday through Friday. A minimum of one cup fruit must be offered on a daily basis for grades K-12.

Citation:

Lunch menus for the selected week of review, April 17-21, 2023, were evaluated and the following problems were identified:
1) The dark green, red/orange, and beans/peas (legumes), vegetable subgroups were not offered any time during the week evaluated for all grade groups. The minimum weekly requirement must be met for each vegetable subgroup for all grade groups.
2) The site did not offer two fat-free or a low-fat (1% milk fat or less) and a fat-free milk options for all grade ranges. Students must be offered two different milk choices for all grade groups.
3) It could not be determined if the daily meat/meat alternate requirement was met on Friday for all grade groups because an adequate Child Nutrition (CN) label or Product Formulation Statement (PFS) was not available for the beef stew. Appropriate nutrition documentation must be available to validate the contributions of the food items to the meal pattern requirements.

Citation:

Breakfast menus for the selected week of review, April 17-21, 2023, were evaluated and the following problems were identified:
1) At least 80% of the grain/bread ounce equivalents offered for the week were not whole-grain rich. At a minimum, 80% of the grain/bread ounce equivalents required each week must be whole-grain rich for grades K-12.
2) The amount of fruit juice available to students on a weekly basis exceeds the allowable amount. The amount of juice available on a weekly basis must not exceed half of the total weekly fruit portion.
3) The site did not offer two fat-free or a low-fat (1% milk fat or less) and a fat-free milk (two milk options). Students must be offered the appropriate milk choices.
Appropriate documentation must be available to validate the contributions of the food items to the meal pattern requirements.

Food Safety, Storage, and Buy American

Citation:

Temperature logs are not documented on a daily basis. On a daily basis, the temperatures of prepared cold/hot foods and all storage areas (dry storage, coolers, freezers, etc.) must be recorded. These temperature logs must be maintained on file for six months.

Counting and Recording Daily Meal Totals

Citation:

While on the day of review the counting method was acceptable, it was discovered that during the month of review (April 2023) the site had not utilized an acceptable meal counting system at breakfast and lunch because meal counts were not taken at the point of service after all components were offered. All meal counts must be taken and recorded on a daily basis at the point of service which is where a determination can accurately be made that a free meal has been served to an eligible child. Fiscal action was not taken since the meal counts were accurate, just the procedure needs corrected.

Sponsor: County of Knox

Food Safety, Storage, and Buy American

Citation:

A food safety plan has not been developed as required by the Child Nutrition and WIC Reauthorization Act of 2004. A food safety plan should be developed and implemented under the principles of Hazard Analysis and Critical Control Point (HACCP). A food safety plan must be developed and implemented based on the principles of HACCP.

Local Wellness Policy

Citation:

A local wellness policy has not been established. You must ensure this office that a local wellness policy will be developed to comply with program regulations. In addition, a wellness committee must be formed to ensure the local wellness policy is reviewed and updated a minimum of once every three years using the triennial assessment form. The final adopted local wellness policy and the completed triennial assessment must be posted publicly.

Outreach

Citation:

Households have not been notified of the availability of the Summer Food Service Program. Outreach to households regarding the Summer Food Service Program must occur before the end of the school year.

Exhibit 11

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS

J.B.H., by his next friend Debra Medlock, and A.M., by his next friend Rachael Puig, on behalf of themselves and all others similarly situated, Plaintiffs, v. KNOX COUNTY, CHIEF JUDGE RAYMOND A. CAVANAUGH of the Ninth Judicial Circuit Court, BRIDGET E. PLETZ, Director of Court Services of the Ninth Judicial Circuit Court, and WENDI L. STECK, Superintendent of the Mary Davis Home, Defendants.	)	Case No. 24-cv-04096-JES-JEH Hon. Judge James E. Shadid

DECLARATION OF LOUIS KRAUS, M.D.

I, Louis Kraus, pursuant to 28 U.S.C. § 1746, declare as follows:

Expert Qualifications

1. I am currently Professor and Division Director of Child and Adolescent Psychiatry at Rush University Medical Center in Chicago, Illinois. In that capacity, I supervise and train child and adolescent psychiatry fellows in various placements, including in-patient, residential treatment, and outpatient programs for children, adolescents, and young adults. I am also currently the Psychiatric Director at the Sonia Shankman Orthogenic School, a day treatment program for children and adolescents in need of support for profound emotional issues; the Founding Director of the Autism Assessment, Research, Treatment and Services Center ("AARTS") at Rush University Medical Center; and the Medical Director of the Chicago Metropolitan Easter Seals Therapeutic School, a school providing a continuum of services for children with autism. I also

have a private practice where I assess and treat children and adolescents and provide therapy and psychopharmacological services.

2. I have worked with juveniles in correctional settings for the past 34 years, including for nine years from 1990 to 1999 as the treating psychiatrist at the Illinois Maximum Security Youth Center in Joliet, Illinois. From 2003 to 2004, I was a consultant to the Civil Rights Division of the United States Department of Justice on a Civil Rights of Institutionalized Person Act (CRIPA) investigation in Maryland. I also consulted with the American Civil Liberties Union of Illinois in a case challenging conditions in the Cook County Juvenile Temporary Detention Center which resulted in system-wide restructuring of mental health services for juveniles held in pretrial detention. I have served as a consultant on various other correctional and juvenile justice matters. I more recently worked as an expert in Palm Beach County, New York, and in several cases in Seattle, Washington.

3. I have been appointed to serve as monitor in consent decrees involving reform in juvenile justice systems in Arizona and Illinois, both of which included reform to the use of solitary confinement against juveniles in those systems. In my monitor role in Illinois, which is currently ongoing, I am assessing and restructuring the mental health programming of the Illinois Department of Juvenile Justice. *See R.J. v. Mueller*, No. 1:12-cv-07289 (N.D. Ill. Sept. 2012). In the Arizona case, I assisted the Department of Justice from 2005 to 2008 in restructuring the mental health, medical services, and dental services in two state facilities. *See United States v. Arizona*, No. 2:04-cv-01926-EHC (D. Ariz. Sept. 2004).

4. I have also been involved in special education consulting and development of Individualized Education Programs and Plans ("IEPs") for the past twenty-six years. I am currently a consultant on special education issues to over fifteen school districts in Illinois. I typically

complete one educational evaluation every week, assist with developing IEPs, and attend IEP meetings. I have testified regarding special education issues in due process hearings under the Individuals with Disabilities Education Act as well as in other civil cases.

5. I have authored a number of publications on treatment of juveniles in correctional settings. I am the primary author of the American Academy of Child and Adolescent Psychiatry's ("AACAP") Policy Statement on Solitary Confinement. I assisted in the completion of the American Psychiatric Association policy statement on Solitary Confinement of Juveniles. I co-edited two monographs on juvenile justice reform for the AACAP, I co-edited a book through Cambridge University Press entitled *The Mental Health Needs of Young Offenders*, and also edited a book through the Child and Adolescent Psychiatric Clinics of North America entitled *Adjudicated Youth*, published in January of 2016. I wrote the Practice Parameter for Child and Adolescent Forensic Evaluations for child and adolescent psychiatry, which was published in the Journal of Child and Adolescent Psychiatry.

6. I have served in a number of professional appointments in my field. From June 2014 to 2015, I served as the chair-elect of the American Medical Association's Council on Science and Public Health, and from 2015 to 2016, I served as chair. From May 2012 to May 2015, I was the chair of the American Psychiatric Association's Council on Children, Adolescents and Their Families, which I had served in as a member for 18 years. From October 2000 to October 2015, I was the chair of the AACAP's Juvenile Justice Reform Committee, and from 2011 to 2013, I was chair of the AACAP Assembly.

7. I was on the Board of Directors of the National Commission of Correctional Health Care ("NCCHC") from 1997 to 2003. I was appointed chairman of the NCCHC Committee on Juvenile Health Care from 1999 to 2003 and served as vice-chairman of the same committee in

1998.

8. I obtained my Doctor of Medicine degree, M.D., from the Chicago Medical School in 1987 and my Bachelor of Science degree, B.S., from Syracuse University in 1983.

9. I include a copy of my Curriculum Vitae to this report which includes all publications that I have authored in the previous ten years. *See* Exhibit A. I also include a list of the cases that I have testified in as an expert at trial or deposition during the past four years. *See* Exhibit B.

Professional Opinions Regarding Practice of Solitary Confinement

10. In this present case, I was asked by the ACLU of Illinois to evaluate the effects of solitary confinement on children in connection with this action challenging the conditions of confinement at the Mary Davis Detention Home ("MDH") in Galesburg, Illinois.

11. For the purpose of preparing this declaration, I reviewed the Illinois Department of Juvenile Justice's 2022 and 2023 audits of MDH, which described the facility's use of solitary confinement, among other things. I also reviewed the complaint in this case and the declarations of the young people that were submitted with the complaint in this case. I understand that MDH's policy and practice is to isolate children in solitary confinement for more than 20 hours a day and sometimes for days at a time, in locked cells alone, depriving them of meaningful social interaction, environmental stimulation, outdoor recreation, educational instruction, access to personal property, and adequate sanitation.

12. I also understand that there are no mental health professionals on staff at FCJDC.It is my professional view, based on over three decades of academic and professional experience, that children detained in extended solitary confinement as described above and by IDJJ's report—whether for administrative or disciplinary reasons—are at risk of serious harm.

13. The AACAP defines solitary confinement as the placement of an incarcerated individual "in a locked room or cell with minimal or no contact with people other than staff of the correctional facility." The NCCHC defines solitary confinement or "isolation" as "the housing of an adult or juvenile with minimal to rare meaningful contact with other individuals" who "often experience sensory deprivation and are offered few or no educational, vocational, or rehabilitative programs."

14. Solitary confinement can be dangerous for anyone, but juveniles are especially susceptible to the severe and devastating psychological impacts of solitary confinement because of their ongoing physical, social, psychological, and neurological development.

15. The risk of harm from solitary confinement exists for all children, even for short periods of time, and increases with the length of confinement.

16. Medical research on adolescent brains explains why juveniles are more vulnerable to the negative effects of solitary confinement. In the adolescent and young adult brain, the connections between the frontal lobe and the mid-brain have not fully developed. The mid-brain, which is the part of the brain responsible for the flight-or-fight response, is firing away. If an adolescent is traumatized in certain ways, it can cause permanent changes in brain development and create a higher risk of developing permanent psychiatric symptoms like paranoia and anxiety. This trauma in the developing brain can likely lead to changes in brain structure for these juveniles. Trauma, such as what is induced by solitary confinement, has a high likelihood of causing these permanent changes.

17. Based on knowledge of the brain development and the impact of adverse childhood experiences on the physical, mental, and behavioral health of children and adolescents, experts agree that children subject to solitary confinement in the criminal justice system are at increased

risk for adverse reactions.

18. These risks are even more pronounced for children who have mental illnesses or developmental disabilities. Children with mental illness constitute a high proportion, at least 60%, of the population in the juvenile justice system.

19. Solitary confinement negatively impacts juveniles by perpetuating, worsening, or precipitating mental health concerns, including but not limited to post-traumatic stress disorders, psychosis, anxiety disorders, major depression, suicidal ideation, suicidal intent, self-mutilation, and suicidal behavior. Solitary confinement has a high likelihood of bringing on acute symptomatology, even if the symptomatology is not already present in the individual. For the estimated 60% of youth in correctional settings who already have this symptomatology, the incidence of presenting it again after solitary confinement is much higher.

20. There is a clear medical consensus that for those juveniles with mental illnesses, the risk of serious harm from solitary confinement is especially great. People with mental illnesses already have deficits in their brain structure or biochemistry. They have weakened defensive mechanisms, making them less resilient than the general population. They are at a higher risk for mental health symptoms and are more susceptible to the significant trauma of social isolation. The trauma of social isolation that can occur for those with mental illnesses will be even more significant and long-lasting than for those without a mental illness.

21. There is a high correlation between juvenile suicide and the use of solitary confinement in detention, including when solitary confinement is used for short periods of time. A national study by the U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention found that half of youth who committed suicide in juvenile facilities were in isolation at the time of their death and more than 60% percent of young people who committed suicide in

detention had a history of being held in isolation. Of the children held in detention centers, suicides occurred within the first 4 months of confinement, with 40% of those suicides occurring within the first 72 hours. This evidence demonstrates a substantial risk of serious harm that can be fatal for children exposed to solitary confinement for even short periods of time.

22. The absence of mental health treatment and intervention for children placed in solitary confinement exacerbates these harms and dangers.

23. Solitary confinement can cause long-term harm, including chronic conditions like depression which, in teenagers, can manifest as anger or as self-harm. Children who experience depression and anxiety are at a higher risk of presenting with these diagnoses again after their release from solitary confinement. In addition, the damage from solitary confinement associated with low self-esteem, vegetative features, and hopelessness associated with depression can be similarly long-standing. Depression in the general population is generally associated with a standard 10-15% mortality rate for suicide, and solitary confinement increases the risk of depression and suicide substantially compared to the general population.

24. Solitary confinement of juveniles can also lead to long-term trust issues with adults, including paranoia, anger, and hatred directed at others. This makes it difficult to create a trusting, therapeutic relationship. It can also lead to noncompliance with treatment in the future, making it hard for people to get the help that they need to address the mental health concerns resulting from solitary confinement.

25. In my experience, juveniles placed in solitary confinement also exhibit fear, dissociative episodes, and anxiety, which may lead to increased levels of hopelessness, paranoia, and lack of trust in others resulting from the arbitrary nature of the use of solitary confinement as a punishment in detention. This creates an anxious and fearful environment for the children even

when they are not in solitary confinement, as they cannot predict which behaviors will result in their placement in solitary confinement again. Furthermore, when children are subjected to open-ended, and repeated, solitary confinement it exacerbates mental health conditions as they perceive that they are subjected to seemingly interminable periods of time in isolation. Children experience time differently—a day to a child feels longer than a day to an adult—and have a greater need for social stimulation. Juveniles should be managed in a correctional setting using defined structures for behavioral management and imposition of discipline, as well as mental health interventions.

26. Children that I have interviewed in various detention facilities, including those that documented as having a pre-existing mental illness or suicide risk, have reported they had the following symptoms (or that symptoms became worse) while they were in solitary confinement: depression, distrust, fear, anxiety, thoughts of self-harm, sadness, and engaging in self-harm. These harms are consistent with the literature about the damaging impacts of solitary confinement.

27. For these reasons, several health, medical, corrections, and professional organizations have condemned solitary confinement of children recognizing that they are particularly vulnerable to the adverse psychiatric consequences of such confinement. The American Academy of Child and Adolescent Psychiatry opposes the use of solitary confinement for juveniles in correctional facilities, recognizing the damaging impacts from solitary confinement relevant to adolescents' developmental vulnerabilities and that the majority of suicides in juvenile correctional facilities occur when the individual is isolated or in solitary confinement. The National Commission on Correctional Health Care, a major accrediting agency, takes the position that juveniles should be excluded from solitary confinement completely. The American Medical Association has called for correctional facilities to halt the isolation of juveniles in solitary confinement for disciplinary purposes. The American Psychiatric Association has supported this

position statement. The United Nations Rules for the Protection of Juveniles Deprived of their Liberty specifically prohibit the solitary confinement of juvenile offenders. The World Health Organization has recognized that solitary confinement is particularly harmful to children, noting the particular vulnerabilities of children, who are developing physically, mentally and socially, and the high rates of mental illness and suicide among young people. The United Nations Standard Minimum Rules for the Treatment of Prisoners, revised in 2015 as the Nelson Mandela Rules, completely prohibit solitary confinement for children. The Council of Juvenile Correctional Administrators opposes the use of solitary confinement for juveniles based on research that shows that placing detained youth in isolation has "negative public safety consequences" and "does not reduce violence and likely increases recidivism" and can cause "permanent psychological damage" and is highly correlated with suicide. In 2016, the United States Department of Justice ended the practice of using solitary confinement for juveniles in all federal prisons because of the growing consensus of the risk of harm for children.

28. Research studies and professional guidelines on the potentially damaging effects of solitary confinement are evolving, namely, that mental health professionals, institutions, and government agencies have formed a consensus that solitary confinement is deeply problematic, and correctional systems must find better ways to manage incarcerated individuals—particularly when they are juveniles.

29. The harm that children suffer as a result of solitary confinement becomes more severe when there is no programming or environmental stimulation, as well as when the cells and facility are in poor physical condition. Denying children educational opportunities further exacerbates an already harmful environment.

30. I also understand that youth housed at MDH have been subjected to regular strip

searches, including facility-wide, fully naked strip searches during which staff required youth to spread their buttocks, perform jumping jacks, and bend over and cough. These types of experiences are particularly traumatic, degrading, and harmful for minors. Because trauma during adolescence may have a particularly significant effect on the development of the brain's frontal lobe, the trauma from these kinds of invasive procedures can result in lasting consequences into adulthood. Combining these kinds of traumas with those children are already experiencing as a result of solitary confinement further compounds the harm done by strip searches, and even further exacerbates an already harmful environment.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 27th day of May 2024.

Respectfully submitted,

/s/ Louis Kraus, MD _____

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